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ABSTRACT

This evaluation report, one of four volumes dealing with the CARE (Children's Agencies, Resources, Etc.) Linkages Project in Tennessee, describes the development, implementation, and results of the interagency committee model used in the project. The project's goal was to foster collaboration leading to more effective linkages between publicly funded child care and development programs and other service providers. The model for promoting collaboration involved a state level Core CARE Committee and eight county-level CARE Committees. The Core CARE Committee promoted coordination among statewide agencies, while the local CARE Committees focused on developing linkages among local agencies and individuals. These local committees met monthly for 9 months. The impact of the CARE project was measured by administering a pretest and posttest telephone survey to over 100 preschool program directors and by documenting the actual events that occurred in counties as a result of project activities. Results indicated that the interagency committee is an effective model for bringing about collaboration. Survey responses did not show substantial differences between the eight intervention counties and eight comparison counties in attitudes toward coordination. However, documentation of local CARE Committee activities indicated that the committees went through a process that resulted in a high degree of collaboration to address local preschool needs. Addenda consist of a bibliography and survey instruments. (CB)

FINAL REPORT

C A R E

LINKAGES PROJECT

FINAL EVALUATION REPORT

OF

THE CARE (CHILDREN, AGENCIES, RESOURCES, ETC.) LINKAGES PROJECT

AN ACTIVITY OF THE

TENNESSEE CHILDREN'S SERVICES COMMISSION

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Special thanks also go to Dr. Margaret G. Phillips, Project Officer, United States Department of Health and Human Services, for her guidance, support and assistance in promoting this project.

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Dr. Karen Edwards
Executive Director, TCSC

Executive Summary

Final Evaluation Report of the CARE Linkages Project

Many preschool programs do not offer or have access to a comprehensive range of services to meet the individual needs of the children they serve. Professionals and parents have long felt that better coordination and collaboration among and between preschool programs and other service providers is needed to help alleviate this situation. The CARE (Children, Agencies, Resources, Etc.) Linkages Project was designed to foster collaboration among and between publicly funded child care and development programs and other service providers in order to ensure that preschool children served in these programs would receive more of the health, education, and social services that they need. The project was a research and demonstration project funded by the U.S. Department of Health and Human Services.

A CARE Linkages model for promoting collaboration was developed and the results documented. The model consisted of creating a state level Core CARE Committee and eight county-level CARE Committees in selected model sites. The emphasis of the Core CARE Committee was to promote coordination and collaboration among statewide agencies serving preschool children, to respond to problems identified by the CARE Committees, and to serve as an advisory body to the project. The emphasis at the local level was to facilitate collaboration and develop linkages among local agencies and individuals serving preschool children such as preschool program directors, health care providers, and social workers. These CARE Committees met approxiamtely monthly for nine months working on solutions to commonly identified local needs.

The impact of the CARE Linkages Project was measured in two ways. First, a pre- and post-test survey of preschool program directors was conducted to assess attitudes toward collaboration and perceptions of the effects of collaboration on children and staff. A second measure of impact was documenting the actual events that occurred in counties as a result of CARE Committee activities. Based on the literature review and telephone survey, the CARE Linkages Project is apparently the first to include a systematic evaluation of collaboration efforts and their impact.

Results indicate that the interagency committee is an effective model for bringing about collaboration and that it appears to work well in a variety of geographic settings. Survey results indicated an initially high and continued interest in collaboration among project directors. Survey responses did not indicate substantial changes between the intervention counties and a group of comparison counties on attitudes toward collaboration. On the other hand, documentation of local CARE Committee activities indicated that, in general, the committees went through a similar process over time which resulted in a high degree of collaboration to address a small nuber of significant local preschool needs. A number of factors were documented which appear to enhance or hinder collaborative efforts.

Several products were produced by the CARE Linkages Project including a literature review, an annotated bibliography, a series of brochures on sharing health, mental health, education and social service resources, a listing of state and federal resources to Tennessee preschoolers, and a guide to implementing a local collaborative effort using an interagency committee.

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Background and Project Overview

Young children need security for the present, they need health to grow; they need skills for the future. Many programs and services are available to respond to the needs of preschool children, particularly those who are handicapped or at risk and/or from low income families. However, even with the variety of programs and services that exist, the comprehensive needs of many preschool children are still not being met. Much of this problem is due to the fact that the need for preschool services far exceeds their availability. For example, a recent study of preschool services for handicapped and high-risk children in Tennessee estimates that preschool programs are available to about one third of the children who need them. But this problem is also prevalent among preschoolers who are already enrolled in preschool programs. This is due to the fact that many programs do not offer or have access to a comprehensive range of services to meet the individual needs of the children they serve. Professionals and parents have long felt that better coordination and collaboration among and between preschool programs and other service providers is necessary.

In the fall of 1981, the Head Start Bureau of the Administration for Children, Youth and Families issued a request for proposals to develop national research and demonstration projects to increase the collaborative efforts between Head Start and other preschool programs in order to improve the provision of needed health, education and social services. The CARE Linkages Project proposal, submitted by the Tennessee Children's Services Commission, was awarded funding as one of these projects.

About the Commission

The Tennessee Children's Services Commission is a state agency created in 1980 by the General Assembly. Its primary purpose is to work with state agencies, child advocacy groups, interested citizens, and other public and private organizations to improve the quality and quantity of services available to children in Tennessee. The commission is actively involved in improving the coordination of services among state departments, developing uniform standards for services to children, collecting data and statistics, and keeping programs and citizens better informed about children's issues. Currently, TCSC has a small, central staff and eight district coordinators located throughout the state. A nine-member board of commissioners advises and oversees staff activities.

Major ongoing activities of the commission include following and reporting on state and federal legislation impacting children and families, assisting in the implementation of a statewide foster care review system, staffing regional Children's Services Councils or Coalitions, distributing a variety of juvenile justice funds, and supporting the state's Healthy Child Initiative. The CARE Linkages Project was one of four major projects being carried out by TCSC in conjunction with this initiative which has focused the state's attention on addressing the needs of babies and preschool children.

Definitions of Key Terms

The terms collaboration, coordination, cooperation and linkages are used, often interchangeably, by many professionals, service providers,

parents and advocates in reference to improving the delivery of comprehensive services to preschool children. While similar in nature, distinctions in the meanings of these terms can and ought to be made. For the purposes of this report these terms are defined as follows:

Cooperation is a more informal process of organizations working together to meet goals. For example, The Local Education Agency requests statistical reports be completed by preschool program to assist in planning. Preschool program directors agree to complete the statistical reports so that children they serve with special needs will have an appropriate program when they reach school age.

Coordination is defined as a formalized process of adjustment and/or utilization of resources (Black and Kase, 1982). For example, The Local Education Agency writes an interagency agreement with a private agency serving multi-handicapped children to serve school age deaf-blind and orthopedically handicapped children of the district.

Collaboration is viewed as a more intensive, planned effort by organizations resulting in a productive meeting of agencies on a point of mutual concern and commitment. Collaboration refers to the process through which organizations go to reach some mutually positive result. For example, Several preschool program directors become concerned about the limited early identification and screening being done. The directors contact other preschool directors and service providers to meet about their concern. The group organizes several screenings in the area and decide to meet regularly to discuss other concerns and sponsor annual screenings.

Thus the concepts of cooperation, coordination and collaboration can be viewed as an increasingly involved and potentially beneficial continuum as far as meeting the individual needs of children in preschool programs.

Linkages are the formal or informal arrangements between agencies to achieve common goals by working together. In other words, linkages are the outcomes of the processes of coordination and collaboration. For example, two agencies have recognized inservice training for working with handicapped preschoolers as a need. They have identified appropriate sources of training and have agreed to conduct joint annual inservice training.

Project Resources

To carry out the CARE Linkages Project, the Tennessee Children's Services Commission was awarded a two-year grant for the period of September 30, 1982 through September 29, 1984. During this period, the project expended approximately $172,832.

Project staff included: the Executive Director of TCSC (10% time in-kind); a state linkages coordinator (100% time) who staffed the Core CARE committee, analyzed data, wrote reports and prepared publications; eight district coordinators (50% time) who conducted the surveys of preschool program directors and developed and staffed the local CARE Committees; and a

local linkages coordinator (50% time in-kind) who supervised the district coordinators.

Equally important to the project as resources were the many people who participated on the state and local CARE Committees and provided the ideas and energy to improve services to Tennessee preschoolers. They deserve much of the credit for the success of this project.

Project Description

The CARE (Children, Agencies, Resources, Etc.) Linkages Project was designed to foster collaboration leading to more effective linkages between and among publicly funded child care and development programs and other service providers in order to ensure that preschool children served in these programs would receive more of the health, education and social services that they need. The project involved both development and research aspects.

The CARE Linkages model that was developed centered on the formation of two levels of interagency committees: one at the state level called the Core CARE Committee and eight at the local (county) level referred to simply as CARE Committees. The emphasis of the Core CARE Committee was to promote coordination and collaboration among statewide agencies serving preschool children, to respond to problems identified by the CARE Committees, and to serve as an advisory body to the project. The emphasis at the local level was to facilitate collaboration and develop linkages among local agencies and individuals serving preschool children such as preschool program directors, health care providers, and social workers. These CARE Committees met approximately monthly for nine months working on solutions to commonly identified needs. A literature review and telephone survey were conducted early in the project so that model development could benefit from as well as complement other collaborative projects.

The CARE Linkages Project was intentionally designed with a strong research component so that it would be clear what the results of the project had been and what factors and conditions encourage and discourage agencies from working together. The results that were obtained from implementation of this model were measured in two ways. First, prior to establishing any of the local CARE Committees and again at the end of the project, an extensive survey was administered to preschool program directors in the eight intervention counties. Preschool directors in eight other closely matched counties where no CARE Committees were formed were also administered the same before and after surveys. The survey covered such areas as attitudes toward collaboration, the effects of collaboration on program staff and the number and types of linkages that exist between programs. A total of 120 preschool program directors participated in these lengthy surveys. A second measure of impact was documenting the actual events that occurred in counties as a result of CARE Committee activities. Based on the literature review and telephone survey, the CARE Linkages Project is apparently the first to include a systematic evaluation of collaboration efforts and their impact.

Results of the CARE Linkages Project indicate that the interagency committee is an effective mouel for bringing about collaboration and that it appears to work well in a variety of geographic settings. Survey results indicated an initially high and continued interest in collaboration among project directors. Survey responses did not indicate substantial changes between the intervention counties and a group of comparison counties on attitudes toward collaboration. However, the Local CARE Committees did appear to go through a similar process over time that resulted in a high degree of collaboration and a small but significant number of linkages occurring in each of the intervention counties.

Developing and Assessing The Interagency Committee Model

The purpose of the CARE Linkages Project was to demonstrate a way to develop collaborative efforts among preschool programs and other service providers which would increase the degree to which children enrolled in preschool programs received the health, education and social services they needed. The model that was developed and tested to accomplish this centered on the formation of two levels of interagency committees; one at the state level called the Core CARE Committee, and eight at the local (county) level referred to simply as CARE Committees. The primary emphasis of the Core CARE Committee was envisioned as promoting coordination and collaboration among statewide agencies serving preschool children, responding to problems and barriers identified by the CARE committees, and serving as an advisory body to the project. The emphasis of the local committees was seen as facilitating collaboration and developing linkages among local agencies and individuals serving preschool children such as preschool program directors, health care providers, and social workers.

The Tennessee Children's Services Commission initially selected the interagency committee model because of the experience and success it has had in using this approach to address other children's issues. Even though the decision on what type of model would be developed was already made, additional information was needed to determine exactly how the model would be structured and implemented in order to increase measurably the likelihood that children in preschool programs would receive the health, education and social services they needed. A clearer perspective on coordination, collaboration and linkages was necessary, particularly of factors which tend to enhance or obstruct the formation of such relationships between agencies. In addition, the specific research issues to be investigated in this project needed to be elaborated and translated into a meaningful research design. It was essential that information and results from previous collaborative efforts be analyzed so that the research component of this project would address important issues that complemented and did not duplicate other projects.

Thus, the process of developing the interagency committee model actually involved three major stages: 1) building on existing knowledge through gathering and interpreting current information on collaboration; 2) using this information to flesh in the model prior to its implementation; and 3) developing a compatible research design to measure the effects of the model. These stages are described in the following three sections.

A. Building on Existing Knowledge

The first step toward gathering and interpreting existing information was to identify appropriate sources of information on collaboration theory, efforts and results. Two major sources, publications and directors of recent collaboration projects were identified and utilized to develop the model. The following two subsections summarize existing information on collaboration gathered by staff through a review of the literature and telephone surveys of directors of related projects. The literature review covered the historical development of coordination, theories of coordination, descriptions of various collaborative models, factors which tend to encourage and discourage collaboration, and research findings. The surveys of related projects were

conducted to gather similar and more in-depth information on projects which had not been fully reported in the literature.

1. Review of Literature

A review of the literature relating to collaborating indicates that there has been an historical development of this concept. Human services organizations have been involved in interagency cooperation since the establishment of charity organizations in the early 1900's (Brim, 1983; Kamerman and Kahn, 1976; O'Connor et al., 1984; Rogers and Mulford, 1982). The earliest forms of cooperation and coordination occurred in an effort to provide services only to the "deserving poor." This involved primarily coordination of specific cases, but was also recognized as a way to avoid duplication in soliciting for funds (Rogers and Mulford, 1982). During this period competition was valued and most organizations took an individualistic approach. The relatively few human service agencies basically looked out for themselves and cooperated when it was to their own advantage. This atmosphere continued until the early 1930's when, as a result of the great depression, many more human services and agencies were created by government.

The New Deal Era was a time when the ideology of many managers changed from independence to a recognition of the important role of social cooperation. This was due in part to public attitudes. There was growing pressure from society that the coordination of the increasing number of public welfare agencies was necessary and should be the responsibility of the public sector to carry out. The federal government attempted to exert some control through financial and administrative strategies to integrate programs. However, the boundaries between public and private responsibilities were considerably blurred and fragmentation of services continued to be a problem due to the desire of many organizations, both public and private, to protect their own "turf" (Rogers and Mulford, 1982).

Corporate management or bureaucracy was accepted as a viable organizational form during the 1940's. The emphasis was on clear lines of authority, division of labor, establishment of rules and coordination of activities.

In the 1950's, the orientation of human service organizations began to change from coordination to planning. Representatives from the community began to be included on planning councils (Rogers and Mulford, 1982).

The 1960's were a time when the federal government began to show an interest in documented efforts at coordination. In 1960, a report was published by the federal government describing various methods of interagency coordination (O'Connor et al., 1984; Rogers and Mulford, 1982; Urban and Rural System Associates, 1977). The Federal Intergovernmental Cooperation Act of 1968 gave states a new, more active role in coordination. This act also gave further impetus to coordination of human service organizations through its emphasis on program budgeting and cost effectiveness. As a result, the late 1960's was a period of increased attempts to coordinate efforts through centralized control and service integration.

Service Integration is a process which seeks to coordinate public and private agencies by creating a new administrative relationship (O'Connor et al., 1984; Rogers and Mulford, 1982). It was thought that service integration would eliminate fragmentation and gaps in services as well as unnecessary duplication while enhancing service delivery due to centralized funding and planning (Rogers and Mulford, 1982). However, there were a number of factors which worked against centralized planning during the late 60's and early 70's and still do so today. These factors are the importance of local control, concerns about unequal distribution of power and shortages of time and funds (Rogers and Mulford, 1982).

Even though there was a great deal of emphasis placed on coordination by governments during the 1960's and early 70's, this was also a period of tremendous growth of social programs, particularly in the mid 1960's under the banner of the "Great Society." The literature does not indicate widespread successes in coordination efforts during this period.

By the late 1970's and early 80's, this picture began to change. More localised efforts and emphasis on coordination began to appear. For example, the California legislation mandated a study of coordinated child care (Urban and Rural Systems Associates, 1977). Massachusetts regarded coordination favorably and began sponsoring a series of coordination efforts in 1977 (Massachusetts State Implementation Grant, 1981). These efforts by states were to some extent a bearing of fruit from the federal policies which had, since the late 1960's, encouraged coordination based on the assumption that coordination and planning will result in better utilization of resources and improve the quality of resources offered (Jones, 1975; Loadman et al., 1981; O'Conner et al., 1984; Rogers and Mulford, 1982; Schaffer et al., 1983; Trist, 1977; Urban and Rural System Associates, 1977). These efforts were also, no doubt, related to the slumping economy and the tightening of resources available to human service agencies. Efforts of coordination increase during periods of reduced government funding, increased accountability and increased demands for services (Brim, 1983; Clark, 1965; Galaskiewicz and Shaten, 1981; Jones, 1975; Loadman et al., 1981; Miller, 1984; Milliken, 1983; Rogers and Mulford, 1982; Schlesinger et al., 1981; Schmidt et al., 1977; Trist, 1977). Strategies and philosophies about coordination appear to be closely related to general environmental conditions of the time (Rogers and Mulford, 1982).

It was also during this period that the concept of collaboration began to emerge as a needed and more sophisticated level of coordination.

From an historical perspective, emphasis on agency interaction has shifted from cooperation to coordination to collaboration. In fact, evidence suggests that individual organizations attempting to work together tend to follow the same continuum (Black and Kase, 1963; Schwartz, t al., 1981). Unfortunately the three terms have often been used interchangeably which has contributed to much confusion about definitions (Hord, 1980).

Cooperation is the process of informal working together to meet the day to day goals of the organization (Black and Kase, 1963). Coordination is more a formalized process of adjustment or utilization of existing resources through integrated action of two or more organizations (Black and Kase, 1963; Hall et al., 1977; Halpert, 1982; Hutinger, 1981; National Juvenile Justice

Program Collaboration, 1981; Schaffer et al., 1983; Tads et al., 1982. Co-
laboration is viewed as a more intensive jointly planned effort by organiza-
tions over a mutual concern which results in a mutually desired result.
(Black and Kase, 1982). Coordination and collaboration are not static
processes but are continually changing to meet the changing needs and demands
of society, and are rarely neutral (Davidson, 1976; Hutinger, 1981; Trist,
1977). As a fairly new concept, less has been written about the theory and
practice of collaboration as compared to coordination. However, much of
what has been written about coordination applies to collaboration as well.

Most efforts at coordination are based on organizational exchange theory which states that an exchange is any voluntary activity between two or more organizations which has consequences, actual or anticipated, for the realization of each organization's anticipated goals (Levin and White, 1961). Three main elements are necessary for exchange to occur: clients, labor services and resources. In periods of scarcity interorganizational exchange is essential for survival of organizations (Levin and White, 1961). For agencies to be interdependent each agency must be accessible to necessary elements from outside or clients, the objectives of each organization must be related and there must be consensus among the organizations about each organization's domain (Levin and White, 1961).

Coordination of human services organizations involves social control. The optimum is most likely to occur when bureaucratic organization and external primary groups develop coordinating mechanisms. These groups tend to "balance their relationships" at a central point of social distance, allowing some intimacy and some separation (Litwak and Meyer, 1966). This is important since most organizations express concern that coordination will result in loss of control (Fabrizio and Bartall, 1977; Hall, 1977; Reid, 1964; Rogers and Mulford, 1982; Schwartz et al., 1981).

Several different models have been described as effective in encouraging and stimulating coordination and collaboration (Black et al., 1980; Bowes-Keiter, 1983; Elder and Magrab, 1980; Fabrizio and Bartel, 1977; Galaskiewicz and Shatin, 1981; Hutinger, 1981; King, 1978; Magrab et al., 1981; McDonough, 1980; McPherson, 1981; National Juvenile Justice Program Collaboration, 1981; North Central Regional Center for Rural Development, 1979; O'Connor et al., 1984; Reid, 1964; Reid and Chandler, 1976; Rogers and Whettin, 1982; Rogers and Whitney, 1976; Tindall et al., 1982).

The interagency committee model is a group made up of representatives from community agencies and other groups from the related area. The purpose of this group is to improve interagency communications, to identify needs, locate gaps and advocate for changes. The interagency committee usually has no authority but depends on the involved agencies commitment and abilities (Pritchard, 1977).

Another model discussed in the literature is the single portal entry model which as the name indicates establishes a key person or agency to act as broker or to coordinate services. For this model to be successful there must be close and continuous communication between the key person or agency and other community agencies (Pritchard, 1977).

Several variations of the above models and other models have been described, such as the lead agency model, a variation of the single portal model, development of a written agreement between two agencies, and the services integration model (Pritchard, 1977; Reid, 1964; Reid and Chandler, 1976; Rogers and Mulford, 1982).

Many of the projects discussed in the literature had two components, a state level and a local level interagency council. State level committees usually are responsible for coordinating the collaborative effort, advising local committees, evaluating the collaborative effort and funding projects if money is available. The local level committees are responsible for the planning, development and implementation of the collaborative effort, assessing local needs and recruiting and organizing volunteers. One of the problems reported with this bi-level model is local committees feeling that state level committees are dictating activities without any real knowledge of real local needs (King, 1978; Nelkin, 1983; Rogers and Whitney, 1978; Tendal et al., 1982).

All the models described involve linking of agencies or programs to another. There is some confusion about the use of the word linkages (Tindall et al., 1982). Linkages are the actual activities or arrangements that result from agencies collaborating that lead to the commonly desired outcome. (Galaskiewicz and Shatin, 1981; Tindall, 1982). Establishing interagency linkages is recognized as a difficult process which should be approached on an incremental basis (Elder and Magrab, 1980; O'Connor et al., 1984).

Many efforts of coordination and collaboration, incorporating each of these models, have been described in the literature. Regardless of the model utilized, certain factors have been identified which are conducive or disruptive to the collaboration process (Barbieri, 1982; Black et al., 1980; Bowes-Keiter, 1983; Caruso, 1981; Elder and Magrab, 1980; Fabrizio and Bartel, 1977; Hutinger, 1981; Justiz, 1983; King 1978; McDonough, 1980; McPherson 1981; National Association of Counties Research, Inc. 1983; National Juvenile Justice Program Collaboration, 1981; Nelkin, 1983; Provan et al., 1980; Reid and Chandler , 1976; Rogers and Whitney, 1976; Schaffer et al., 1983; Schlesinger et al., 1981; Schwartz et al., 1981; Whitted et al., 1983).

In order for successful collaboration to occur, all agencies involved should recognize that a problem exists and reach concensus on its nature and scope. A clear mutual purpose should be identified, agencies should have similar goals, and representatives to committees should have similar status (Caruso, 1981; Elder and Magrab, 1980; Reid, 1964; Reid and Chandler, 1976). Key organizations should be identified and commitment should be secured from each, consensus should be reached about objectives of the effort, and clear delineation of responsibility should be developed; evaluation and identification of benefits should be ongoing and some mechanisms for resolving disputes should be established which will encourage negotiations (Audette, 1980; Hord, 1980; Hutinger, 1981; Litwak and Hylton, 1962; Magrab et al., 1981; Schwartz et al., 1981; Whitted et al., 1983).

Factors that have been identified which will disrupt the collaborative process are competition for funds, turf protection, and vested interest, unclear roles and purpose, fear of loss of organization identity, domination by more powerful agencies, differing interpretation of laws, policies and

regulations, differences in philosophical and theoretical perspectives, lack of time, and history of previous failed attempts (Black et al., 1980; Elder and Magrab, 1980; Hutinger, 1981; Lacour, 1982; National Juvenile Justice Program Collaboration, 1981; Rogers and Mulford, 1982; Schaffer, 1983; Schwartz, 1981; Wheeler Tall, 1980; Whetten, 1982).

An ideal approach to the collaborative process has been described by a number of authors and includes a number of specific steps. The first step is to assess interest in and readiness for a collaborative effort. Next, identify participants for the collaborative effort, agencies that will benefit from the effort and have something to contribute to it. The third step is to clearly define the purpose of the effort and build it. Building the collaborative effort should include obtaining individual agency commitments to the collaborative effort; creating a clear statement of purpose and rules of procedure. The fourth step is to discuss and resolve issues relating to competition, vested interest and turf Meetings should be held on neutral turf to encourage full involvement. The fifth step is to identify key actors and to get their support. The sixth step is to have agencies and persons involved share resource information, identify areas of need, and share ideas on collaboration. Step seven is to develop a plan for the collaborative effort taking into consideration the identified needs, resources and previous experiences. The eighth step is to get commitments from the agencies involved for time and staff support as appropriate (Elder and Magrab, 1980; Fabrizio and Bartel, 1977; Hutinger, 1981; Magrab et al., 1981; National Juvenile Justice Program Collaboration, 1981).

Collaboration and coordination are assumed to have positive impact on service delivery (Gage, 1977; Jones 1975; Loadman et al., 1981; O'Connor et al., 1984; Rogers and Mulford, 1982; Schaffer et al., 1983;). Most of the literature indicates that collaboration will cause increased cooperation and more effective contacts between agencies, will bring about needed change, will help to stretch scarce resources, will enhance capacity of organizations involved to dominate the environment, and will help eliminate duplication of services as well as identify gaps and increase planning efforts (Barbieri, 1982; Black et al., 1980; Caruso, 1981; Elder and Magrab, 1980; Gabel, 1980; Hutinger, 1981; LaCour, 1982; McPherson, 1981; Provan et al., 1980; Smith-Dickson and Hutinger, 1982; Southern Regional Education Board, 1981). However, the expectations that many benefits result from collaboration have very limited documentation through research or in the literature (Elder and Magrab, 1980; Rogers and Mulford, 1982). The benefits which have been documented several times are increased cooperation and communication (Black et al., 1980). Further research is needed on the actual impact of cooperation on service delivery system, strategies used, models, the characteristics of interorganizational linkages and the actual network (O'Connor, 1984; Whetten, 1982). Most of the research that has been done is comparative. There is a need for some logitudinal studies. Further research needs to be done on the methods of evaluation, barriers to collaboration and factors which would encourage collaboration (Brim, 1983; Whetten, 1982). Research that has been completed on collaboration has indicated mixed results (Whetten, 1982). Some collaborative efforts have found that reduced funding does not necessarily increase collaboration, but has in some instances brought about the deterioration of such structures (Miller, 1984).

2. Survey of Related Projects

In conducting the review of the literature, a number of recent collaborative projects were cited but not specifically described. Some of the projects were currently in existence. Since many of these projects related to preschool programs and services, CARE Linkages staff felt it was important to obtain whatever additional information these projects could provide which would guide the development of the model and particularly the research design. In order to gather this information, staff conducted telephone surveys with eight of the most closely related projects.

In order to consistently gather the most pertinent information, a structured interview survey was developed and conducted with a director or other contact person from each of the identified projects. The interviews lasted approximately one hour. The interview questions were grouped according to five areas of interest and relevance to the CARE Linkages Project. These areas were: 1) project background--when and why the project was initiated, whether the project was still in operation, what was the funding source; 2) project description--major goals and objectives, the types of geographical regions in which the project was conducted; 3) collaboration description--types of collaboration strategies used, types of agreements drafted; 4) assessment--use of instruments to assess needs, attitudes, barriers and/or effectiveness of the project; and 5) additional considerations--problems encountered in conducting the project; other people to contact and/or literature to consult. Particular attention was placed on identifying any research findings or measurable results from these projects since so little of this type of information had been reported in the literature. Responses to the questions in each of these five areas are summarized below.

Project Background

Initiation

All but one of the projects involved in the telephone survey had been initiated in the late 1970's. Three had begun in 1977, two in 1978, and three in 1979 while one was initiated during 1974. Although all projects had experienced some changes, only one--State Implementation Grant (SIG)-Maine--has ended completely. This project was initiated in 1977 and was terminated in 1981 at the end of the grant period. Another project, the Regional Clinics Project in Iowa, has officially ended but the collaboration has been maintained. Thus, despite shifts in funding sources and reductions in funding levels, many of the projects surveyed continue to operate in some capacity. One program, the Grand Junction Collaborative Project was, surprisingly, initiated and continues to function without external funding support.

Funding

Two projects were supported by State Implementation Grants (SIG), two by the Office of Maternal and Child Health and Special Education (Crippled Children's Division), one by Developmental Disabilities (DD), one by an unidentified federal grant, and one by private foundation sources and in-kind contributions. As previously noted, one project operated without funding. Information on the funding source of one project could not be obtained.

Both SIG's ended after 5 years of funding; SIG-Kansas, however, was still in operation though with limited funds from other sources. The two projects funded by the Office of Maternal and Child Health ended in September, 1983; however, one of the projects--the Utah Project--continues as a regular state function. The Montana Project, initially federally funded, is also now under state funds. Project ECHO, initiated with DD funding, was switched to U.S. Department of Health, Education and Welfare funding and is presently funded by local sources. The Michigan Family Neighborhood Project, supported initially by the Kellogg Foundation, Merrill Palmer, and the local school system is now receiving funds from several different sources.

Project Description

Purpose

Although all the projects surveyed were designed to coordinate services for preschool children, the goals and objectives of the projects were quite diverse. For some, interagency collaboration was the primary purpose of the project. Two projects, for example, were developed in response to a Request for Proposal (RFP) to establish interagency collaborative efforts. The Grand Junction Collaborative Project was also designed specifically to coordinate the delivery of services to young children for screening purposes. In other projects, collaboration was apparently chosen as the method having the best potential for dealing with specific problems. Among the problems tackled by these projects were:

- o developing assessments of cognitive development;
- o provision of evaluation and diagnostic services to preschool children;
- o increasing school academic achievement;
- o provision of early education to the handicapped; and
- o refinement and testing of various developmental scales.

Agencies Involved

Most of the interagency projects involved several agencies in the areas of health, education, and social services. Among the agencies often involved in the collaborative efforts were the Department of Social Services, the Department of Public Health, Head Start, the Department of Mental Health and Mental Retardation, and the Department of Education. Hospitals and public school systems were also major participants in most interagency efforts.

Target Population

The majority of projects were aimed at coordinating and improving services for young children (age unspecified); only two projects apparently covered a 0-21 age range.

Geographical/Demographic Regions

Three projects--Project ECHO, Utah, and the Grand Junction Project--were single county projects. Although both SIGs were statewide projects, the SIG-Kansas project was designed to include all of the state's school systems while the Maine project focused on a restricted number of sites chosen through grant competition.

The Iowa Regional Clinics project was conducted in 18 of 99 counties that were selected because of their interest in and cooperation with the project. The Montana project was of similar proportion, involving 17 counties from the state's eastern regions.

The Michigan Family Neighborhood project was the most unique of those surveyed. This project was conducted in a neighborhood that had developed in an old army camp. In this project, the coordination of early intervention services was viewed as the most efficient approach to counteract extremely low academic levels.

Collaboration Description

Models

The interagency committee model was the most common model of collaboration used by the projects surveyed. Five of the 8 projects employed this model, although for some, the model was used only in the initial stages of the project. The remaining projects used a variety of models. In the Iowa Project, only one preschool program and the Department of Social Services were targeted for collaboration. A third party consultant was employed to initiate the collaborative efforts in the Michigan Family Neighborhood project; when the funding ended, however, the consultant was replaced with a lead agency. In Kansas, the decisions were made by local committees although often one person ended up in charge or a lead agency surfaced.

Aspects Involved in Collaboration

A number of different aspects were involved in the projects' collaborative efforts. Even with projects that focused on one activity or service there were a number of aspects of the activity or service that were included in the collaboration. In the Iowa project, for example, the intent was to develop procedures to use in place of the Denver Developmental Scale to assess cognitive development. Although the focus of the project appeared to be quite narrow, a number of aspects were involved in the working relationship between the public schools and the Department of Social Services. Among these aspects were screening and evaluation, Child Find services, staff, equipment, materials, and facilities.

Decisions regarding what to include in the collaborative efforts were most often guided by perceived need and resource availability. When need was the basis of a decision, it was typically identified in an informal manner rather than through any formal or standardized needs assessment. Although staff in the Utah project performed a phone survey to assess needs, the survey was recognized as an informal attempt to justify a decision that had already been made rather than to guide a future decision.

Collaborative Agreements

Eight of the projects surveyed accomplished primarily informal, verbal agreements. Only in the Utah Project were formal written agreements developed between the Departments of Health and Education. In addition, although most of the collaborative agreements were informal in the Michigan Family Neighborhood project, written letters of agreement were drafted to bind the school system's agreements with the local hospital and with the city

government. Similarly, the majority of the agreements in the SIG-Kansas project were informal; written agreements were only necessary to establish and maintain collaboration between Head Start and the local education agencies.

Most of the agreements that were formed by the projects surveyed involved two parties although two projects reported having agreements that involved as many as ten parties.

The individuals interviewed had difficulty responding to questions concerning how agreements were reached and the factors that determined the type of agreement that was reached. There did not appear to be any single, clearly delineated process for reaching agreements. A few projects reportedly relied on the interagency committees to develop the agreements while in other projects, agreements were reached after the parties involved became aware of each other's needs and resources. Among the factors that reportedly affected the types of agreements that were drafted were the amount of time and red tape involved in reaching an effective agreement, prior specifications (i.e., as stipulated in an RFP), and the types of rules or by-laws formulated by the interagency committee.

Common agency needs and interests, similar philosophies, and effective working relationships were seen as the essential components to binding cooperative agreements. Optimistically, even in projects that have been terminated (e.g., SIG-Maine) or that have had drastic funding cutbacks (e.g., Michigan Family Neighborhood Project), most of the collaborative agreements continue to operate.

Assessment

A major section of the interview concerned the types of assessments that were employed to assess agency needs and to measure the effectiveness of project efforts. Since the literature search did not reveal any research studies focused on collaboration, it was hoped that the telephone survey would uncover as yet unpublished research and evaluation efforts. It was discovered, however, that none of these interagency projects included any systematic evaluation or research component. Thus, the guidelines offered by these projects for developing assessments of needs, attitudes, barriers, and project effectiveness were based on opinion and anecdotal evidence rather than on empirical research findings. The information obtained for each of these assessment areas is presented below.

Needs

None of the projects incorporated an assessment of agency or community needs. One project included a cursory phone survey to assess needs but, as mentioned earlier, conducted the survey to justify past actions rather than to guide future decisions.

Attitudes

Respondents were asked if they had made any attempts to discover the types of collaborative efforts that would be acceptable to the agencies involved in their projects. Two projects--SIG-Kansas and the Utah project--reportedly made no attempt to assess attitudes toward collaboration in

general nor to assess attitudes toward specific types of collaboration. The ramifications of this oversight were particularly meaningful for the Kansas project; in one instance, the unwillingness of one agency's staff to take the necessary steps to become certified thwarted attempts to link the agency with local education agencies.

In two other projects, although attitudes were not assessed, it was recognized by the interagency committees that monetary collaborative agreements would not be acceptable to the agencies involved. Thus, in the Michigan project, methods were chosen that utilized available resources while in the Grand Junction Collaboration project, all developmental screenings were accomplished without money exchange.

Respondents were also asked to state the most acceptable and least acceptable types of strategies they attempted to implement. Among the most acceptable efforts were reportedly those that reflected the interests of the people involved and those that involved all agencies as equal partners. Among the least acceptable efforts were those involving turf issues, those requiring an additional outlay of staff time, and those involving attempts to include physicians in the collaboration.

Personality, interest, and commitment were perceived as the key ingredients to successful collaboration. In the Kansas project, for example, the most successful efforts were believed to be those that centered around a group of people who were very interested in what they were doing and who displayed a great deal of enthusiasm in their work.

Barriers

In three projects there had reportedly been some attempt to anticipate the types of obstacles that could block or decrease the efficacy of their interagency collaborative efforts. In the Iowa project, for example, it was recognized that collaboration could not be implemented in urban areas where staff were already overworked and understaffed.

Although there had been attempts to identify barriers prior to project implementation in only 3 of the projects, six respondents were able to report barriers they had confronted after the projects had been in operation. Among the barriers cited were funding problems, territorial protection by individual groups, time and red tape, staff cutbacks, personality conflicts, agency unawareness of the benefits of collaboration, and providers who agreed to collaborate with the hope of having their own problems solved rather than with the expectation of working with others to solve mutual problems.

Success of Collaboration

All but one of the respondents considered their projects' efforts to be very successful. None of the projects, however, conducted a formal evaluation of their collaborative efforts. Although a few projects did include evaluation efforts, they were focused on the primary issue (e.g., provision of developmental screenings) rather than on the collaborative efforts. Thus, the only assessments of collaboration that appear to have been conducted were indirect and correlational.

Changes in Collaboration

It was also of interest to learn if there had been any changes in the original collaborative agreements or in the relationships between and among agencies. Most projects experienced periodic changes in funding and in the availability of resources that affected the types of collaborative arrangements that could be made. In one project, personality conflicts created a dynamic interagency situation that, at times, thwarted the interagency council efforts; this situation, however, appears to be an exception to the experiences of the majority of interagency collaborative projects.

Additional Considerations

Problems Confronted

Those interviewed were asked to share accounts of any problems they may have encountered in implementing their projects. Four were able to recount at least one specific problem they had encountered in trying to get their projects off the ground. A major problem, as noted throughout this report, was funding, both with respect to changes in sources and to changes in funding levels. Other problems cited were:

- o difficulties in effectively linking service providers in urban areas;
- o difficulties in establishing interagency agreements at the state level, and
- o difficulties in involving physicians in collaborative arrangements.

Experts in Interagency Collaboration

One finding of this telephone survey was that there appears to be a fairly well defined network of individuals who are experts in interagency and service delivery collaboration. Drs. Phyllis Magrab and Jerry Elder were the two persons most often recommended to contact for additional information. Both have written a considerable number of articles and handbooks on collaboration, many of which have been reviewed for this project.

B. Fleshing in the Model

The review of the literature and the survey of related projects indicated that there are a number of models which have been developed with the purpose of increasing the coordination and collaboration process among and between agencies and service providers. The interagency committee model has been the most frequently used model. In fact, many projects have used models with state and local committees similar to those proposed in the CARE Linkages Project. While research findings were not available to indicate the degree of success of this model versus any of the others, opinion, anecdote experiences, as well as what limited evidence of results exist suggest that the interagency committee model has at least as much potential to bring about collaboration as any other model. Thus, the decision to develop this model was confirmed.

In addition to confirming the interagency committee a viable model in general, the literature review and the survey of related projects raised

issues and provided directions which were used by project staff to flesh in the CARE Linkages model.

1. Factors such as having mutual interest, having similar status and philosophies, and getting all potentially affected parties involved indicated the importance of getting the right people involved on these committees. Staff determined that key types of people to be involved in both the state and local CARE Committees should be thought through and identified prior to implementing the model. Based on concern that all parties who were essential to a collaboration agreement be involved, a decision was made that all of these committees would be broad-based and thus fairly large in size. Having many people involved potentially would have led to greater disagreement and difficulty in reaching consensus. However, the sense from previous collaborative efforts that having everyone participate who needs to be involved overruled this concern.

2. The length of time other projects have been in operation and some of their achievements suggests that collaboration can be successfully promoted. Although shifts in funding sources and cutbacks in support has created problems in the past, funding does not appear to be the critical determinant of collaboration success and survival. Rather, it appears that there must be a core unit of enthusiastic and committed individuals if collaborative arrangements are to be maintained. Thus, for the CARE Linkages model, these findings suggest that one key role of the district coordinators may be to maintain committee morale and enthusiasm.

3. Previous collaborative projects which experienced the highest degree of success tended to focus on a single or very few specific objectives; even in those projects which had been in operation for several years. Both the literature and previous project directors strongly suggested that it would be unmanageable for the committees at either the state or local level to focus on more than one or two activities over the limited period of this project. Thus a key role for the state linkages coordinator and particularly the district coordinators would be to help the committees to focus their energy on a few important needs rather than to fragment their efforts.

4. The literature strongly suggests that committee members need a clear sense of their purpose from the very beginning. Thus it was determined that staff needed to spend considerable portions of the first meeting or more, if necessary, of each committee so that all committee members would clearly understand and accept their role and objectives.

5. Since common agency needs and interests were believed to be critical ingredients to binding agreements, it appears essential that the programs and agencies involved have an opportunity to communicate and share information concerning the services they offer and those which they would like to offer or improve. Furthermore, the information gathered indicated that collaboration was much more likely to occur when committee members attempted to address a common need which was perceived by all as being important to address. Thus, staff felt that a local needs assessment should be conducted as part of the model.

6. Several of the related projects that were surveyed indicated that the degree to which they were able to get committee members to collaborate varied somewhat according to population of the area. (In several instances it appeared more difficult to get agency personnel in urban areas to fully participate in collaborative efforts.) CARE Linkages Project staff felt this would be an interesting area to explore since Tennessee has many population and geographic differences. Four population/geographic areas were selected for study as part of implementing the model at the local level. They were urban areas, rural areas, Appalachian areas, and rapidly growing, so called, new urban areas.

7. Recognizing the fact that many barriers to providing preschool children with the services they need will require long-term solutions and that more than one problem was likely to exist that committees would like to address, project staff felt that part of the measure of success of this model would be whether the committees continued beyond the funding period for this project. In order to increase this probability, project staff felt that district coordinators should not serve as committee chairmen. Instead, the intent would be for the committees to quickly elect their own chairperson, make as many decisions as they could on their own, and then carry out their own projects in order to reduce dependence on the district coordinators.

8. Due to the lack of existing research findings relating to the impact of collaboration efforts, special emphasis needed to be placed on the process the local committees went through as they attempted to collaborate and also on measuring the results. (See next subsection on developing the research design.)

In essence then, based upon the literature review and survey of related projects, the two level interagency committee model proposed by the Tennessee Children's Services Commission was fleshed in so that committee membership would include fairly large numbers and variety of persons who would affect or be affected by collaborative efforts; that the committee would identify common needs; that they would function as independently as possible from the project staff in selecting and addressing a manageable number of issues; that the local committees would be established in four different population/geographic areas in order to explore how this might affect the impact of the model; and that as much of the process and outcome of the committees would be documented and measured.

Implementing and Assessing the Interagency Committee Model

Implementing and assessing the interagency committee model consisted of four key phases: 1) selecting the counties to participate in this project; 2) developing instruments to assess the impact of this project; 3) preparing project staff to implement and assess the model; and 4) creating and working with the CARE Committees. Each of these phases is described in more detail below.

A. Selecting the Counties

The "subjects" involved in the CARE Linkages Project were sixteen of Tennessee's ninety-five counties. Eight of these counties were to serve as treatment counties; that is, district coordinators associated with the project would create interagency committees in those counties as a means to promote collaboration among and between preschool programs and service providers. Since existing information indicated that geographic or population characteristics of an area could potentially affect the outcome of collaborative efforts, the first step in selecting counties was to develop appropriate categories. Urban, new urban, rural and Appalachian were categories which seemed appropriate to the geographic/population characteristics of Tennessee. Project staff defined these categories as follows:

Urban - A metropolitan area where at least 500,000 people live within a distance not exceeding 45 minutes travel time from its center by means available to the majority of the population (radius of approximately 30 miles). Included in this are one or more central counties containing the area's main population concentration and outlying counties which have close economic and social relationships with the central counties. It should have at least 500 people per square mile.

New Urban - This area has a population concentration of at least 50,000 inhabitants and generally consists of a central city and the surrounding, closely-settled contiguous territory (suburbs). Its population has increased to new urban status during the past decade. The population increase is due to a positive migration rate of at least 15%. The growth rate of the area is 30%-70% over the past decade. It may be included in an urban/metropolitan area.

Rural - A rural area or county is made up of small towns with the number of inhabitants less than 150 per square mile. A rural county may not be included in an urban/metropolitan area. It has a low per capita income and a low tax base.

Appalachian - Appalachia covers the entire physiographic region of 109,500 square miles embraced by the Appalachian portion of nine states (Tennessee, Maryland, Virginia, West virginia, Kentucky, North Carolina, South Carolina, Georgia and Alabama). An Appalachian county is an isolated community due primarily to poor roads and geography. It is usually composed of company towns where there is only one major industry. Specific indicators are a high emigration rate, high unemployment rate (over 13.7%), and a high poverty level (over 16.4%).

District coordinators and Core CARE Committee members were then consulted in an effort to eliminate counties they felt would not be receptive to the project as either treatment or control sites (a very small number). Next, the state linkages coordinator compiled demographic and sociological data on all of the viable counties. Using their data, each viable county was placed in one of the four geographic/population categories. Once this was done, counties within each category were matched on the basis of population per square mile, percentage of population graduated from high school, unemployment rate, and number of preschool programs. Project staff debated whether number of preschool programs in a county should be used as a site selection criteria and, if so, how. A decision was made that while counties with few programs might need assistance in developing additional programs or services, this was really not the intent of this project. Rather, the project's focus was on developing linkages among existing programs. Thus, a greater number of preschool programs, more specifically, a greater number of public funded and/or non-profit preschool programs were determined to be a desirable characteristic to be considered in site selection. Eight pairs of matched counties were selected which would result in an approximately equal number of urban, new urban, rural and Appalachian counties. One county in each pair was then randomly selected to be a treatment county. The resulting treatment counties were Shelby, Davidson, Bradley, Bedford, Weakley, Cumberland, Scott, and Greene representing 2 urban, 1 new urban, 3 rural and 2 Appalachian counties respectively. The comparison counties were Knox, Hamilton, Putnam, Coffee, Gibson, Johnson, Monroe and Claiborne, representing 2 urban, 1 new urban, 2 rural and 1 Appalachian counties respectively.

B. Developing Assessment Instruments

Two types of assessments were carried out in the CARE Linkages Project. One was meant to identify changes that occurred in preschool program directors that could be attributed to whether those directors received the treatment or not. In order to assess such changes, a telephone survey was developed. The survey was designed to be a one-hour structured interview. The surveys were administered to preschool program directors in all treatment and control counties during September 1983 by district coordinators prior to creating any local CARE Committees. District coordinators called ahead to schedule the interviews and conducted them with program directors who were outside their own districts. Surveys, slightly revised to reduce length, were administered to the same program directors in June 1984. The survey was written to address factors identified in the literature or based on related projects that could influence the impact of collaborative efforts or indicate whether changes had occurred due to the project. Various sections of the survey addressed the following questions.

Section A of the survey asks questions about the program such as its size, the type of children served and government interventions such as budget cuts. Section B addresses the program's need to improve current services; need to offer additional services; as well as past collaborative efforts and the program's willingness to collaborate with others in the future. Section C asks about the program's current collaborative efforts in the community at large, such as participation in interagency conferences. Section D asks questions about the program director's knowledge of and relationship with other programs and agencies. The program director's attitudes toward collaboration are addressed in Section E. Section F addresses the program

director's perceptions of the positive and negative consequences of collaboration, while Section G addresses perceptions of the barriers blocking collaboration in the program director's home county. Characteristics of the program directors such as previous experience, education and age are addressed in Section H. (See Addendum C.)

The second type of assessment carried out by this project involved careful documentation of the process the local CARE Committees went through and what actually occurred in their counties as a result. In order to identify and consistently document the process and outcomes of each of the eight local CARE Committees, a documentation notebook was prepared by the local linkages coordinator with assistance from the state linkages coordinator for use by each district coordinator. The notebooks contained eight sections with accompanying explanation sheets so each coordinator knew what information to collect and how often to collect it. The eight sections were:

Coordinator Checklist - This section contained a list of what data the coordinators should keep before, during, and after each meeting and what material should be sent to the central office.

Membership - This section included a form for listing each committee member's name, address, phone number, and reason she/he was included on the committee; an attendance form; a form to indicate persons who declined to participate, special problems encountered in securing desirable numbers, and changes in committee composition during the project.

Agenda - This section was provided for the coordinator to file meeting agendas.

Minutes, Handouts, Committee Meeting Climate Surveys - This section was provided for the coordinator to file the minutes, handouts and committee meeting climate survey form for each meeting.

Desirable Linkages - This section included a form for the coordinator to list all the ideas which the committee generated for collaborative effort.

Barriers - This section included a form for the coordinator to list all barriers or impediments to collaboration which committee members identified during the course of the project.

Products - This section was provided for the coordinator to file any correspondence, reports, forms, newspaper articles, agreements, etc., which were an outgrowth of collaborative activities.

Support - This section included forms for the coordinator to log all activities she engaged in related to the maintenance and support of the committees.

In addition, gaining a sense of how the committee functioned, that is its climate, and how that changed over time was viewed as important due to

its potential impact on the collaboration process. In order to assess committee climate, a rating scale called the Committee Meeting Climate Survey (see Addendum D) was developed. This survey contained ratings on source of meeting leadership, style of leadership, number of persons who participated and who generated ideas, willingness to work together, ease in reaching agreement and degree of reality-based planning. District coordinators completed this climate survey after each CARE Committee meeting.

C. Preparing Project Staff

Due to the complex nature of the assessment instruments and the many factors that had been identified which could foster or inhibit the process of collaboration, it was considered essential to thoroughly prepare the district coordinators for the key role they were to play in creating and assessing the local CARE Committees. In preparation for administering the telephone survey, two inservice training sessions were held for the district coordinators who would actually administer it to preschool program directors. These sessions were conducted by a project consultant, and the state linkages coordinator who worked jointly to develop the survey. The first inservice session was a participatory feedback session where the research consultant sought comments and suggestions on a draft of the survey. The survey was revised accordingly over the next several weeks. The district coordinators then role-played by administering the survey to each other in a second inservice meeting. This helped to familiarize district coordinators with the instrument, anticipate responses and questions, and estimate the time needed for completion. A third phase of survey training occurred in August 1983. During that month district coordinators actually pilot-tested the survey on preschool program directors who were not from the sixteen treatment or control counties. Actual surveying of project counties took place in September 1983.

In addition to training on the survey instrument, several inservice sessions were also provided by the state and local linkages coordinators for the district coordinators on creating, staffing and documenting the activities of the local CARE Committees. A training module was developed and presented to district coordinators over several days which: focused on conceptualization of the CARE Linkages Project; existing knowledge pertaining to collaboration; how the counties were selected; the importance of assessing project results; who to include on the committees; how to invite their participation; planning and conducting the initial meeting; factors that enhance or inhibit collaboration; and the role of the district coordinators in relation to the committees.

As a result of these inservice sessions, lists of suggested local CARE Committee members were developed based on the geographic/population characteristics of the county.

Suggested Rural and Appalachian Committee Members

1. Public preschool program (Title XX, DD, MRMR, PIG, CHAD, university) directors.

2. Private, not-for-profit day care programs--directors.

3. Private, for profit day care programs--directors (if needed or if interested).

4. Head Start--director/social services coordinator.

5. Department of Human Services--
   a. licensing counselor--regional office
   b. director or designee of county office.

6. Health and Environment--nurse/CHAD rep./health promotion coordinator/ nutritionist/extension agent.

7. Local school system(s)--K supervisor or board designee for each school system (county, city) in the county.

8. Mental Health Center--C & Y Director.

9. Private medical provider.

10. Local related agencies and organizations (if needed)--
    a. interagency councils
    b. civic/volunteer groups
    c. local AYC, PTA
    d. business/industry

Suggested Urban and New Urban

1. Public preschool programs (all persons interviewed to include Title XX, DD, MHMR, PIG)--directors.

2. Private, not-for-profit day care programs (if interested)--directors.

3. Head Start--director/social services coordinator.

4. Department of Human Services--
   a. licensing counselor
   b. social services supervisor/dept. designee.

5. Health and Environment--Director of Nursing

6. Local school system(s)--director(s) of Preschool Program or K supervisors.

7. Mental Health Centers--Outreach Program director or designee.

8. Private medical provider--pediatrician, dentist, speech therapist and OT or PT therapist if applicable.

9. Related agencies and organizations--AYC representation.

These inservice sessions also generated a single suggested agenda to follow at the first CARE Committee meeting and clarified the role that district coordinators should play.

A significant amount of time was spent preparing staff to implement this project. This was done primarily so that staff would have a clear understanding of the project, the concepts involved and their own expectations. It was also done so that implementation of the model would be as consistent across the eight treatment counties as possible so that differences that occurred on the survey results and/or on the documented process and outcomes of the committees would not be due to differences in the way district coordinators implemented the model.

D. Creating and Working With the CARE Committees

The CARE Linkages model is based on the formation of two levels of interagency committees, one at the state level called the Core CARE Committee and eight at the county level called CARE Committees.

The Core CARE Committee was created in March 1983. It was comprised of nineteen members representing state policy makers, child care program directors, including Head Start directors, private service providers, representatives of state-wide technical assistance and training organizations, early childhood experts and church representatives. A chairman for the committee was selected prior to the first meeting by the project director. The committee met eight times between its creation and the end of the project in September 1984.

The functions of the Core CARE Committee, as determined by project staff prior to the first meeting were to:

1. serve as a sounding board as well as an idea-generator for innovative linkage strategies in model sites;

2. assist in monitoring progress occurring in model sites;

3. serve as facilitators/strategists for developing state linkages within and between their departments/agencies and other departments/agencies involving approach to take, key people with whom to negotiate, how to work through the system)—primarily concerned with policy changes;

4. assist in development of implementation plans for linkages with their respective departments/agencies on a regional or local level;

5. review materials developed for use in the project, such as the telephone survey, as well as other written products provided for dissemination; and

6. to assess existing statewide preschool needs and to select one or two of these needs to collaborate on.

The role of the state linkages coordinator, who staffed the Core Committee was to:

1. develop meeting agendas in conjunction with the chairperson;

2. take and distribute minutes;

3. serve as a resource person during meetings;

4. prepare materials for use in the meetings;

5. gather appropriate information as requested and as needed by committee members;

6. arrange for guest speakers;

7. communicate information from the Core committee to the local committees and vice versa;

8. to solicit input and assistance from committee members on project products and progress;

9. to assist the committee in addressing one or two selected needs; and

10. writing articles and making presentations on the project.

At the initial meeting of the Core CARE Committee, the roles of the committee and staff were discussed. Details and timelines of the project were presented. Other noteworthy collaborative efforts in the state were highlighted. Reactions were solicited on potential treatment and control counties. A list of desirable preschool services was started.

The actual intervention in the CARE Linkages Project began in October and November 1983 when the eight local CARE Committees were convened for the first time. District coordinators formally contacted potential members from the suggested list developed at the inservice meetings. The district coordinators set the time and place of and also led the first meeting. The agenda of all of the first meetings was very similar to the one developed during inservice training. Among other items, it consisted of introductions, a presentation by the state linkages coordinator on the nature of the CARE Linkages Project, a summarized presentation for each county of its own results from the needs assessment questions (Section B) contained in the survey of preschool program directors. This served as an excellent starting point for the committee members to begin discussing and identifying needed collaborative efforts. District coordinators encouraged the committees to elect their own chairperson. In conjunction with electing a chairperson, each committee was urged to henceforth plan its own activities and meeting schedule in order to address its own selected needs. The roles of the local CARE Committees and of the district coordinators were also discussed at the first meeting.

As determined by project staff, the role of the local CARE Committees was to:

1. mutually agree upon some key issues that adversely affected the provision of needed health, education and social services to local preschool program children;

2. utilize a collaborative process in attempting to address the issue(s);

3. mutually carry out activities which would address the selected issue(s);

4. identify and communicate state level barriers to locally desired collaborative efforts.

The district coordinators carried out a multitude of essential roles throughout the implementation phase of this project. They were the critical people in regard to the CARE Linkages model. Each district coordinator kept a log of all of the activities they engaged in relating to the project. These activities can be categorized under five major roles--research assistant, organizer, secretary, facilitator and staff or resource person.

The district coordinators engaged in the following activities as a research assistant:

1. conducted pretest interviews in treatment and control counties;

2. attended meetings of the Core CARE Committee, gave reports on local committee activities, and relayed information back to the local committee;

3. conducted an evaluation of the project with committee members;

4. conducted post-test interviews in treatment and control counties;

5. recorded or filed all required data in the project notebook and submitted this to the central office at the close of the project.

The district coordinators engaged in the following activities as an organizer:

1. selected persons in the treatment county, particularly the service providers, to serve on the committee;

2. recruited committee members by phone or by visit;

3. convened and chaired at least the first meeting, until the chairperson was elected;

4. during the year, recruited new members in order to broaden representation.

The district coordinator performed the following clerical tasks:

1. arranged meeting place(s);

2. took minutes at meetings (with committees which did not have a secretary);

3. prepared and distributed minutes;

4. prepared and distributed meeting notices and agendas;

5. kept mailing list of members current;

6. made reminder phone calls prior to meetings.

The district coordinators acted as a facilitator in the following tasks:

1. recruited nominees for chairperson;

2. served as a resource person during the meetings;

3. worked behind the scene to clarify tasks, to provide encouragement, and to mediate where there were differences of opinion;

4. during meetings, kept group "on task";

5. served as a liaison in working out shared arrangements (i.e., sharing inservice or sharing parent training).

The district coordinators served as a staff person to the committee, performing the following functions:

1. prepared and duplicated materials for committee meetings—questionnaires, forms, charts, etc.;

2. prepared and mailed any committee correspondence;

3. prepared and distributed news releases regarding the committee and/or its activities;

4. contacted and invited guest speakers for meetings;

5. met regularly with chairperson for planning (seven of the eight committees);

6. wrote articles about the committee for local, regional, or statewide publictions;

7. prepared publicity material for committee projects (such as fliers and posters);

8. solicited community donations for committee projects;

9. spoke to community groups about the CARE Committee;

10. assumed responsibilities for committee projects as a committee member.

Project Results and Discussion

The primary results of the CARE Linkages Project were assessed in two ways. First, the attitudes and perceptions of presc program directors in all of the treatment and comparison counties were surveyed before and after the CARE Committees were implemented. This was done in order to determine whether significant changes had occurred which could be attributed to the CARE Committee intervention. The second assessment centered on documenting the process the committees went through and what actually occurred as a result. Observation and self-reporting on the part of the district coordinators served as the basis for this documentation. The survey results and the documented results are discussed in detail in the following two sections.

A. Survey Results

1. The pre-intervention survey was administered to 120 preschool program directors representing 69 percent of all preschool program directors in the 8 treatment and 8 control counties. The average survey lasted 59 minutes. Out of these 120 directors, 69, or 58% were from treatment counties and 51, or 42% were from control counties. The post-intervention survey, lasting an average of 46 minutes, was administered to 114 of these same preschool directors. Of these 114 directors, 67, or 59%, were from treatment counties and 47, or 41% were from control counties.

   According to the results, 83% of the program directors worked full-time. The average age of the respondents was 42 years, with a range from 26 years to 63 years of age. Eighty-two percent of the respondents were female. Furthermore, respondents indicated that they had been with the programs for an average of seven years. Results indicated that 86% of the respondents had college degrees or more education and 45% had master's degrees or more education. Ninety-two percent (92%) of the survey respondents were program directors, while the remaining 8% had other titles.

   According to the geographic/population categories, 65% of the directors surveyed were from urban, 7% from new urban, 19% from rural, and 9% from Appalachian counties.

2. Prior to the intervention, results of the survey indicated no significant differences in responses between preschool directors in the treatment and control counties. Thus, these two groups can be assumed to be from the same basic populations. Therefore, any difference that occurred on the posttest could more easily be attributed to the intervention and not initial differences in the groups. Since the treatment and comparison groups did not differ, a composite summary of pretest results, including all 120 directors, is reported below.

The survey results indicate that the programs served children with a variety of conditions. The following chart indicates the condition and the percentage of programs which serve each type:

Program Statistics

Types of Conditions Served

Condition	Percentage of Programs Serving
Normally developing	74
Low income/poverty	83
Blind	33
Deaf	35
Physically impaired (orthopedic)	55
Health impaired (including autistic)	51
Seriously emotionally impaired	43
Visually impaired	54
Hearing impaired	52
Speech impaired	82
Mentally retarded and/or developmentally delayed	67
Specific learning disabilities	57
At risk of mental retardation/developmentally delayed	56
Gifted	56

The survey results indicated that 97% of the programs serve three- and four-year-old children, 81% of the programs serve five year olds, 63% serve two-year-olds, and 40% serve children one year old or younger.

Funding and Classification

Responses on questions about funding indicate that 13% of the programs receive Head Start funds, 33% receive Title XX, 9% have Preschool Incentive Grants, 2% receive Child Health and Development funds, 13% receive funds from the Department of Mental Health and Mental Retardation, 4% receive Developmental Disabilities funds, and over 55% receive funds from other public and private sources. Many of the programs have more than one funding source.

Results indicate that 68% of the programs have experienced recent cutbacks and 11% expect cutbacks within the year. Forty-three percent of the programs are classified as public, 51% as private not-for-profit, 3% are church-sponsored, and 14% have other classifications.

Regulations

Respondents indicated that they were required to follow the regulations of the following agencies:

Percent of Programs	Type of Regulation
74	Department of Human Services licensure
17	Mental Health/Mental Retardation standards
7	ACMRDD Accreditation standards
88	State and/or local fire codes
87	State and/or local health/environments
23	Department of Education standards
12	Head Start standards (performance or monitoring site visits
24	Other standards/regulations

Collaborative Activities

54% to 77% of respondents perceived that they were already collaborating on the following services or activities:

-providing inservice training
-serving as field sites for college/university students
-promoting awareness of children's needs
-providing and securing assessments and evaluations
-providing information and referral services.

23% to 45% of respondents indicated a willingness to collaborate on the following services and activities:

-purchasing of supplies and/or food in bulk or wholesale
-providing physical education and recreation
-providing art activities
-making home visits

The following chart indicates the percentage of all pretest respondents participating or interested in collaborative activities.

	Percentage Participating	Percentage Interested
Workshops	95	4
Committees	74	21
Professional organizations	92	6
Child Find	57	37
Info exchange	86	12
Share direct serv.	37	30
Joint discussion	82	14
Health & soc. serv.	44	37

Attitudes Toward Collaboration

94% to 97% of respondents indicated that they agreed with the following statements:

-My program could benefit from collaboration.
-Collaboration can lead to more complete services for preschool children.
-Most programs gain from collaboration.
-Collaboration helps a program to have positive relations with other programs.
-Collaboration would create better communication among preschool providers in the area.

28% to 43% of the respondents expressed concern that collaboration might:

-increase red tape;
-increase paperwork;
-require programs to be more accountable;

-not succeed because preschool programs in the area would be too concerned about protecting their own turf.

Consequences of Collaboration

60% to 68% of the respondents indicated that collaboration would improve the following:

-quality of planning for preschool services;
-communication among preschool programs and service providers;
-advocacy for children;
-relationships among preschool programs;
-sharing of information regarding new practices of serving preschool children.

2% to 5% of the respondents indicated that collaboration would make the following worse:

-use of program staff's time;
-program's ability to serve more children than it does now.

3. Post-Intervention Survey Results

Statistical analyses were conducted in order to determine whether or not the intervention had an impact on the attitudes and perceptions of preschool program directors in the intervention counties. Data from programs in the 16 counties involved were submitted to analysis. Eight of these counties' programs had received the intervention. The assignment of counties to the intervention and non-intervention groups were randomly determined.

Each program completed a set of questionnaires at two different times. the pretest was administered prior to the onset of the intervention and a posttest was administered six months later. Two sections of these surveys were analyzed: the section eliciting programs' attitudes regarding collaboration; and the survey evaluating perceived consequences of collaboration.

A 2x2 Analysis of Variance (ANOVA) was conducted to assess the effect of the intervention on the characteristics considered by each of these surveys. The two factors were Group (intervention and non-intervention counties) and Test (pretest and post-test). On the attitude survey, a significant effect of Test was obtained ($F(1,29)=8.11, p < .01$). This means that a difference was obtained in the scores from one administration to the next. In this case, the source of the effect was that the programs' attitudes regarding collaboration positively increased. However, this increase did not vary as a function of whether the programs were located in intervention or non-intervention counties. The ANOVA conducted on the data furnished by the consequences questionnaire failed to produce any significant differences. The implication of these results is that the intervention did not appear to have a statistical impact on the perceptions of directors from intervention counties regarding the consequences of collaboration.

4. Discussion of Survey Results

The results of the pretest indicated that preschool program directors in both the intervention and comparison counties had very positive atitudes toward collaboration and very positive perceptions of the consequences of

collaboration on their children, their staff and their programs. These extremely positive pretest results may be an indication of how thoroughly accepted the notions of coordination and collaboration are among preschool program directors. This does not mean that these notions are always implemented.

The high scores may also be a result of the county selection process. At the beginning of this project, district coordinators were asked to identify counties across the state which they felt had good potential for preschool program directors and other preschool service providers to work together. The intervention and comparison counties were selected from this pool of "good potential counties." This undoubtedly caused the results to indicate a more positive view of collaboration than if the counties had been totally randomly selected.

A third possible reason for such positive responses was the nature of the survey itself. The survey questions and response categories may not have been neutral enough. That is, it was apparent for many questions what the "best" answer would be. Some directors later indicated that their responses had been somewhat biased toward collaboration because of the way questions were worded. In addition, it appears that respondents interpreted the definitions and concepts related to coordination, collaboration and linkages in different ways. Some directors tended to consider any interaction they had with other agencies as collaboration which contributed to higher collaboration results.

Results on the post-test also showed little difference in the way directors from either the intervention or comparison counties responded. Responses continued to be extremely positive toward collaboration and its effects. In fact, on the post-test survey, the whole group of directors showed a slight, but statistically significant increase in their attitudes toward collaboration. As in the pretest, there was no distinction between the way intervention or comparison county directors responded on the post-test. Thus, in terms of attitudes and perceptions, it appears that the creation of Local CARE Committees did not significantly improve in the intervention counties vs. the comparison counties. This could very well be due to the fact that the attitudes and perceptions toward collaboration of both the intervention and comparison county directors was so high initially.

B. Documented Process and Outcome Results

The collaborative process and outcomes achieved by the local CARE Committees were the focal point of the project. During the first 8 or 9 months these committees existed, they collaborated to successfully carry out a number of local activities to improve preschool services. To a lesser extent, the Core CARE Committee also collaborated on several projects. The process and outcomes of both levels of collaborative effort bears noting.

1. The Local CARE Committees

The official time period for Field Implementation of this project was July 1, 1983 to June 30, 1984. Eight Local CARE Committees were created by district coordinators during October and November 1983. The committees met officially as part of the CARE Linkages Project through June 1984. During this period, these committees averaged seven meetings, a rate of almost one

per month. Committees in three counties held a total of eight meetings; and the remaining county held six meetings. The average meeting length was 1 1/2 hours with a range from 1 hour to 2 1/2 hours.

The actual composition varied for each committee. All the committees had preschool program directors involved, although in the two urban counties, eleven of the programs surveyed did not participate in the committee in that county. The actual number of programs involved in the committee varied with larger numbers being on the urban committees. The involvement of the Head Start directors also varied from county to county. Most of the Head Start directors attended one or more meetings and were found to be very supportive. Preschool program directors serving special populations such as developmental disabilities and mental retardation were the most active participants on the committees.

Participation of the representatives from the various state agencies was good, especially the Healthy Children Coordinators from the Department of Health and Environment.

Representatives from community mental health centers were active on six of the committees. One rural county did not have a representative because they only received mental health services from a regional office staff person twice a month. One of the urban counties had a representative who attended one meeting, but was not interested in participating in the focused activity during the first six months.

Only one of the committees succeeded in getting pediatricians or private medical providers to participate. In fact, two pediatricians and a dentist participated! One of the two pediatricians involved was very active on the committee and was able to involve the local Dental Association in responding to a committee-identified need for dental services.

In the initial meeting of each committee, the district coordinator functioned as the leader of the committee, spending much of the time explaining the project and the role of the committee and assisting the group in assessing needs in the county. With encouragement from the coordinators, most of the committees soon elected their own chairperson. One committee chairperson had been appointed by the coordinator prior to the first meeting; one committee elected a chairperson at its first meeting; four committees elected chairpersons at their second meeting; and one committee appointed a chairperson at its third meeting. In the remaining committee, the coordinator served as chairperson for seven meetings. At the eighth meeting, which occurred after the project officially terminated, the committee elected a chairperson.

Although the data is subjective, results from the Committee Meeting Climate Survey which were completed by district coordinators after each committee meeting, substantial shifts in leadership occurred in most of these committees over time. Coordinators of five of the committees indicated that they perceived the locus of leadership to move gradually from themselves to the chairperson until finally coordinators felt as "one of the group." Committees in two counties were rated as remaining "partially dependent" on the coordinator. The eighth committee remained "totally dependent" on the coordinator for leadership.

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Looking at the number of persons who participated and generated ideas and who were very agreeable to working together, three committees moved in a consistently more positive direction while three others began and remained very positive with high levels of participation and agreement. The eighth committee began and remained fairly guarded with only an average number of persons participating in the meetings.

Details of the collaborative process and activities of each of the eight Local CARE Committees follows.

Bedford County

The Bedford County CARE Committee met a total of seven times. Using the needs assessment from the pretest interviews and applying the nominal group techniques, the group identified two needed services—coordination of inservice training and parenting workshops. In the second meeting, the committee divided into two small groups to discuss each priority. As a result of exploring these two areas, the total group decided to conduct a parenting workshop in the spring. They also chose to pool information and develop a resource directory of children's services in the county.

The remaining meetings of the committee focused on planning for the parenting workshop. All participants were genuinely interested in the project and meeting attendance and participation remained high throughout the winter and spring. As planning evolved, arrangements were made for two workshops for parents: one on parenting young children and one on nutrition; plus a program of entertainment for children.

Prior to holding the April workshop, the group sponsored a pancake supper with McDonald's in order to raise money for workshop packets. Each committee members sold at least 25 $1.00 tickets. Much effort was placed on advertising the workshop—grocery sacks were picked up from grocery stores, printed with ads and returned to stores for bagging grocery purchases; letters went home through school-age children; announcements were made by radio and newspaper; posters were made by a 4th grade class motivated by a poster contest; fliers were sent to businesses, doctors, ministers and day care centers.

The workshop was a tremendous success with approximately 150 parents attending. Three student clubs served as hostesses and baby sitters and two local clubs donated refreshments. The completed directory of children's services was distributed to workshop participants.

At the June meeting, the committee spent considerable time evaluating the workshop and the entire project. The group was enthusiastic about continuing its existence and will reconvene in the fall after a summer break. The committee may sponsor a second workshop (on child abuse awareness) and voiced interest in getting involved with legislative issues. They also decided to explore the possibility of conducting a community Child Find Project in the fall.

Bradley County

The Bradley County CARE Committee, consisting of approximately 15 members, met a total of eight times during the intervention year. The service

provider representatives were very active and showed as much interest in the project as the preschool providers. During the first three meetings, participants discussed priority areas of possible collaboration as revealed by the needs assessment data. In the second and third meeting, the committee selected two projects: (1) to learn how to influence policy makers by holding an advocacy training workshop for committee members and early childhood people in the community, and (2) to conduct a Child Find project. In the fourth meeting, the committees selected two additional goals: (3) to secure needed indigent dental services, and (4) to sponsor needed parenting classes.

Subcommittees were formed to work on each project. Meeting time was used to hear subcommittee reports and to plan as a total group. The committee was quite successful in accomplishing goals by systematically tackling them one at a time. The first event to occur was the advocacy workshop held on March 1, for approximately 20 persons. As a direct result, many committee members began to work actively for the school breakfast program bill in the legislature at that time. The committee also wrote letters to the Regional Health Department requesting that the dental van be scheduled to serve Bradley County low income clients.

A survey of existing parenting classes revealed that available classes were too costly or too categorically restricted for use by many parents. The committee worked out arrangements for suitable parenting classes to be offered by the mental health center during six weeks of the summer. The committee also arranged baby sitting and transportation services for parents who enrolled. This project was completed after the linkages intervention was officially terminated.

In June, the committee pursued their interest in services to handicapped children and arranged for a resource person to speak to them about mandated and actual services for handicapped children. This may well be the beginning of a "Child Find" project for future months. The committee has been so successful that members have chosen to continue functioning despite the termination of the research project.

Cumberland County

The Cumberland CARE Committee met seven times during the implementation period. This is a small county with a committee of approximately eight active members.

During the first and second meetings, the committee identified seven goals based on the needs assessment data for the county and group discussion: 1) shared inservice training; 2) updating an existing service directory; 3) organizing parenting classes/discussion groups; 4) licensure issues--revising center standards; 5) coordinating student exchanges/joint field trips; 6) establishing a transportation task force to identify problems and to make recommendations; and 7) improving awareness of children's services and needs through media coverage.

This committee was unique among the eight in that it did not choose to concentrate on one or two goals, but retained all seven goals as objectives and attempted to work on all. Because the committee was small, one to three persons volunteered or were volunteered to work on each goal. Because most of

the goals were the responsibility of small subcommittees, most work on goals occurred between meetings and meetings were used for reporting small group progress to the whole committee.

The Cumberland County Committee had varying degrees of success in accomplishing its many goals. The committee did sponsor two well-attended, shared inservice training events: one on child abuse and one on music. More are planned for next fall. Infomation was collected for a revised services directory. At the close of the implementation year, the directory was being prepared for typing. A joint field trip (a picnic) of children from three preschools did take place. Barriers regarding programs sharing transportation were identified and were submitted to the Core CARE Committee.

The impact on individual members of the activities undertaken varied. Some devoted time, effort, and resources in implementing projects; others who were either unwilling or unable to commit themselves to participation in particular projects chose to remain inactive. The latter members sometimes continued to attend meetings and to indicate interest in being a part of the group and sometimes dropped off the committee altogether. Of course, some activities of the committee did not meet the needs or elicit the interest of all members. The committee intends to resume meetings in the fall after a summer break. Because the membership of the group is fluid, some members may become active with the initiation of subsequent projects from which they or their constituents may benefit.

Davidson County

The Davidson County CARE Committee, located in an urban setting, held seven meetings between December and June of the official implementation year. The committee initially selected three activities for collaboration: coordination of health assessments, referral programs for placement of children in day care centers, and sharing resources.

Following the second meeting, the committee activities and membership changed significantly. The collaboration activities were changed to (1) bulk purchasing of food and supplies, (2) sharing staff inservice, and (3) parent training activities. At the same time, the size of the committee decreased from 17 to 10 with only 5 to 8 persons attending on a regular basis. There are two apparent reasons for the abrupt change. Historically, there had been two attempts to organize daycare centers to participate in collaborative activities. Both attempts had been unsuccessful and some providers felt this project would be one more failure. Also, because the activities selected were strictly of benefit to day care providers, service providers from human services, public health, mental health felt there was little they could offer or receive from the collaborative effort. Those who remained active were those directors who were really interested in bulk purchasing of food and supplies.

The role of the coordinator was that of an initiator and the leader throughout the project year. Continuing to work with a small number of providers to plan and implement the bulk purchasing project proved to be profitable. After the fifth meeting, new interest developed among providers who were previously inactive. The number of providers interested in bulk purchasing increased to 17. In July 1984, a chairperson was finally selected.

The success of the committee came after the implementation period officially ended. The coordinator and chairperson are currently negotiating bulk purchasing contracts with area vendors who are responding enthusiastically to the idea of a group contract. The committee has decided to remain in existence, to finish their project, and to become a committee of the Mid-Cumberland Children's Services Council.

Greene County

The Greene County Committee, although based in a rural area, had 15 active members including two pediatricians, one nutritionist, a dentist and professors from two local colleges. The committee met seven times during the project year. By the end of the second meeting, the group had selected three activities it wished to pursue: (1) more dental services for low income clients, (2) industry-related child care, and (3) identification of children with special needs. Subcommittees were established to work on activities.

The first successful activity was in the area of dental services. Local dentists were surveyed to determine their willingness to provide free or low-cost services. The dental project successfully involved the local Dental Association in this effort. With their cooperation, a list of five dentists who accept Medicaid or who are willing to accept indigent patients is being circulated to all committee members and to all day care centers in the county.

The subcommittee on the identification of high-risk children developed forms for screening and identification purposes. These forms will be used in an on-going identification project to begin in September 1984. The entire CARE Committee has worked to promote industry-supported child care in the area. This project is still a current endeavor.

This has been a very active committee with good visibility in the community. The activities selected by the committee have had a very positive effect on the members. As a result of working together, many have shared and received services: (1) one program received dental screenings from the health department; (2) directors of private daycare centers are attending Head Start inservice training; (3) one private program provided screenings for Head Start children; (4) a child abuse council was formed and is planning a forum on child abuse for the community; (5) the committee has been asked to serve as an advisory board for a local program; and (6) Head Start has offered educational and audio-visual materials for use by the committee members. At its May meeting, the committee unanimously voted to continue to exist and will have bi-monthly meetings beginning in the fall.

Scott County

The Scott County CARE Committee, located in a rural, Appalachian county, convened eight times during the intervention year. Twenty persons belonged to the committee; approximately ten were active members. Based on the needs assessment data, the group, at the very first meeting, made the decision to develop a directory of preschool services in order to know area programs better and to more effectively refer and place children for services. Forms for collecting information were immediately prepared and completed by members of the committee.

The committee thoroughly explored the possibility of developing a high risk registry as a second project. Because of confidentiality barriers regarding access to information on birth certificates, the group decided at its third meeting not to develop a registry but to conduct a spring child find campaign. The group enthusiastically and ambitiously planned a series of six screenings to be held at different sites throughout the county. Subsequent meetings of the committee were devoted to planning the spring campaign. Specific tasks were identified (dates, location, personnel, target population, advertisement, enrollment, screening activities, financial assistance, outside resources) and members assigned to tasks. Some subcommittees held extra meetings in order to complete their responsibilities.

The six screening events were held during the month of April. Community response to the screening was quite good. Door prizes certainly stimulated attendance; yet cultural barriers (the fierce independence of the local people) and transportation problems in this mountainous area certainly affected the turn-out. Out of the 167 children screened, the most prevalent problem to be identified was dental needs. During the screenings, many immunizations were updated and 35 children were referred to the county school representative, primarily for speech and hearing problems.

At the May and June meetings, the committee arranged follow-up service procedures. The county schools will coordinate these services during the summer months. The committee also decided to meet quarterly next year and to explore the idea of conducting developmental screenings again next spring. The county services directory was completed by the coordinator and was distributed to CARE Committee members; however, lack of funds prevented the committee from disseminating the directory throughout the community.

Shelby County

The Shelby County CARE Committee, in an urban setting, was by far the largest committee, with an average meeting attendance of 20-25 members. The committee was convened later than the others due to a change in coordinators in the region, but it was able to meet six times during the intervention period. In the first two meetings, the committee studied the needs assessment data and generated a list of priority needs for collaboration. From the starting point, they then chose to pursue three goals: (1) to conduct two screening projects for pre-kindergarten children, (2) to conduct a public awareness campaign to inform parents of requirements for registering children in school, and (3) to work on establishing a computerized information and referral system for the county.

Subcommittees were formed to address each goal. The goal to work on a computerized I & R system was later deferred to the Children's Services Council and the entire committee worked on the screenings and the public awareness campaign. The screenings, one at Charjean Elementary School and the others at several locations, were major successes. The first screening involved 15 different agencies/volunteer groups with donations from 12 different businesses. The second screening coordinated efforts of 32 agencies with more than 100 volunteers. The public awareness campaign was in its initial stages at the close of the intervention year. A local industry had donated $150 to the CARE Committee to print posters for the campaign.

The two screening projects had a major impact on the communities. Following these events, the committee received numerous requests from parent groups, neighborhood associations and private schools to hold additional screenings. Many agencies have voiced support for expanded early identification efforts. A second by-product of the screening events was that committee members learned that they had many mutual concerns. What resulted was collaboration on other projects apart from the CARE Committee, e.g., teen parenting centers, sharing of agency resources and even the merging of two agencies.

The coordinator describes this committee as an enthusiastic group of self-motivators and hard workers who see no end to what they can accomplish in the future. This committee will definitely continue to exist and to proceed with planned projects.

Weakley County

The Weakley County CARE Committee, of approximately 13 members, met eight times between October and June to brainstorm areas of possible collaboration and to plan specific projects. When the committee met in October, some members had never met one another; a few knew each other reasonably well; and some had already collaborated with each other on specific projects of mutual interest. Using the needs assessment which resulted from the initial TCSC phone surveys, members systematically worked through the list of potential areas of collaboration to determine which ones would be practical to explore. Early meetings centered on child find, inservice training, confidentiality, and better coordination of services.

Members who had not been referring special needs children to the local school system agreed to do so; time was set aside at each meeting for announcements of upcoming training events; an oath of confidentiality was developed in case the committee wished to discuss the needs of individual children; and much individualized discussion was occurring between members before and after meetings. As the group worked through the list of possible collabortive areas, they sensed the need to carry out a specific project. Consensus was easily obtained at the third committee meeting that the largest unmet need in the county was for a county-wide, multi-disciplinary developmental screening of all preschool children. Since the county school system's Director of Special Education and Preschool Program was elected chairman at this meeting, he was in a position to provide the kind of leadership necessary to successfully carry out such a project.

The remaining meetings of the committee focused on planning efforts to carry out the developmental screening fair. This project was one every committee member could "buy" into because of mutual need and interest. Even though some of the agencies represented on the CARE Committee were already screening their own enrollees, this interagency, multi-disciplinary effort would result in reaching more children and accomplishing a much more comprehensive screening. Because the project caught the interest of everyone, all committee members participated in discussions, and before the planning was completed, all members had contributed ideas and suggestions.

Their efforts culminated in the Weakley County Preschool Screening Fair, held May 12, 1984 at the University of Tennessee at Martin Fieldhouse. Over 160 preschoolers were screened from 10:00 to 3:00 for vision, dental,

speech, hearing, developmental milestones, and health. Many volunteers assisted--students from several university departments, 4 H'ers, scout troops, sheriff's department and city police, health practitioners, and businesses. Much beneficial public awareness and information was disseminated the day of the fair through information booths and, prior to the fair, through media announcements. Every committee member who had been attending meetings was personally present at the fair and participating.

At the June meeting, members agreed that the year had been beneficial enough for the committee to continue even though the research project will be ending in September. The TCSC Field Coordinator will be one of the members although she will continue to distribute announcement memos, minutes and other communications. The committee has elected a recording secretary and will elect a new chairman in January 1985. Meetings will not be monthly during the summer and fall, but members anticipate meeting at least bi-monthly prior to the screening fair which they intend to sponsor again in the Spring of 1985.

2. The Core CARE Committee

The Core CARE Committee met 8 times during the course of this project. Nineteen persons served as members of the committee. Membership included representatives from preschool programs, state agencies, private service providers, statewide technical assistance organizations, early childhood experts and churches. Attendance at meetings averaged 10 with a wide variation from 6 to 14 persons attending different meetings. Attendance at the meetings varied considerably with only 11 members of the committee making 4 or more meetings. Sending representatives added to problems in consistency.

The process that staff envisioned the committee would go through involved drafting a consensus statement of philosophy; identifying preschool collaborative efforts that ought to exist, based on their philosophical stance, and then attempting to address one or two of these needs. It was also speculated that much of the Core Committee's time and energy would be devoted to reducing state-level barriers to collaboration and linkages that were identified by the Local CARE Committees.

In reality, the Core CARE Committee did vote to accept a philosophy statement drafted by staff. In its March 1983 meeting, it began to generate a list of desirable preschool services in the area of physical health, mental health, education and social services. Using this rough list of desirable services, the Core CARE Committee, in its April meeting, was asked to respond to the following questions: "Putting yourself in the position of an administrator of a publicly-funded preschool, what do you see as your major problems in the area of physical health, mental health, social services and education?" Committee members identified three problems in each of the four areas. The "Nominal Group Technique" was used several times to prioritize the problem statements. Taking the top five identified problems in each of the areas, Core CARE Committee members divided into small groups to identify linkages that might solve or eliminate these problems. Then working individually with committee members, district coordinators, and other direct service providers, and by reading literature on networking and copies of collaborative agreements from other states, the state linkages coordinator added to this list. Over the course of several more meetings, where the list was critiqued and then redrafted, the list was finalized and a set of four

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brochures was published in March 1984. They are entitled: Sharing Physical Health Resources at the Preschool Level, Sharing Mental Health Resources at the Preschool Level, Sharing Social Services Resources at the Preschool Level, and Sharing Educational Resources at the Preschool Level. These brochures will be used for planning and developing linkages as well as identifying ways for preschool programs and agencies to share resources.

One of the needs cited by many committee members at the April meeting was the lack of and difficulty in obtaining mental health services for preschool children. Following this meeting, the state linkages coordinator met with the committee's representative and other staff from the Department of Mental Health and Mental Retardation. A survey was drafted and sent to the state's 33 community mental health centers in May 1983. Twenty-six of the centers responded. Results of this survey indicated such things as: eight centers did not have methods for diagnosing and evaluating preschool children; twenty-two centers did not participate in local school "Child Find" efforts to identify handicapped children as early as possible; and only thirteen centers were providing training in early identification of behavioral and emotional problems to preschool program staff.

In March 1984, officials in the Department of Mental Health/Mental Retardation contacted the state linkages coordinator asking if the survey information could be sought from the seven centers which had not responded previously. There was indication that the Division of Mental Health wished to use the survey results in justifying budget requests to expand services as well as to re-establish children and youth program standards for community mental health centers. This rekindled the CARE Committee's interest in this issue and they began to closely monitor the situation. Based in large part on this survey, the Department has now published its intent to re-establish children and youth program standards to be effective July 1, 1985. They have also included an improvement request in their current budget to create 4 new preschool programs to serve 260 additional children.

Another expectation of the Core CARE Committee was for them to address, to whatever extent possible, the state-level barriers to collaboration and linkages that were identified by the Local CARE Committee. Following the activities of and assisting the local committees were among the primary reasons people were interested in serving on the CARE Committee. Several months after their creation in October and November of 1983, the Local CARE Committees began to communicate barriers to the CARE Committee. Five were eventually reported.

1. Transportation issues were: the limited funds available; and reported policies that prevent sharing of Head Start vehicles.

2. With inservice training, an issue was that a Title XX requirement for 243 service days leaves only 3 days for closing a program for inservice after holidays.

3. Confidentiality was a concern for several counties interested in screening and providing special case consultation.

4. Limited resources for increasing services were reported by five of the committees.

5. One committee requested additional copies of the TENN (Tennessee Education for Nutrition) Manual on nutrition for preschoolers.

The Core CARE Committee considered these barriers and investigated the transportation issues. Several successful efforts at shared transportation were presented and the policy from Head Start was sent. The policy indicates that shared use of Head Start vehicles is possible and encouraged. The examples and the correct policy were shared with local committees. The Core CARE Committee felt that the Title XX service days were appropriate and suggested program staff be encouraged to go to training opportunities provided in the community.

The issue of confidentiality was discussed, but committee members recommended a simple confidentiality statement signed by each committee member which would resolve this issue. One CARE Committee had developed such a statement and shared it with other committees.

The concern about limited resources was acknowledged by the Core CARE Committee as valid. The Committee encouraged child advocates and others to encourage increased funding through legislation. The Core CARE Committee did address some concerns about limited mental health services for preschoolers which encouraged the Department of Mental Health and Mental Retardation to increase funding.

The request for additional TENN Manuals was immediately responded to by the Department of Human Services representative.

3. Discussion of Documented Results

While the results of the survey of preschool directors did not and perhaps to some degree were unable to show attitude and perception changes, the documented results indicate that a great many collaborative activities occurred. The establishment of the CARE Committees increased the opportunity for preschool children to get the health, mental health, education, and social services. While it cannot be confirmed through information collected by this project, it is highly unlikely that a comparable amount and degree of collaborative efforts occurred during the same time frame within the comparison counties. In fact, one of the truly impressive overall results of this project was that the local CARE Committees could organize, make decisions and carry out as much collaborative activity as they did in such a short time. Based on the documented results, it appears that an interagency committee model, similar to the one developed in this project, can be highly effective in stimulating collaborative preschool efforts and linkages.

Several key factors stand out as contributors to the overall success of the Local CARE Committees. The needs assessment information, gathered from the telephone survey and presented at the first meeting of the CARE Committees, seemed to provide the committees with a tremendous running start. Committee members did not have to identify issues, get bogged down in personal interests, or debate importance of needs. Instead, the needs assessment provided data on several needs for which there already was apparent concensus. For the most part, committees simply selected from these needs and began planning ways to respond.

A second important factor was the independence of the CARE Committees. Their choice of activities and time schedules was their own. The local committees did not follow and, in fact, were not issued any dictates from the Core CARE Committee. This independnnce led to a wide variety of activities. Such variety made it more difficult to portray a single statewide impact of the project, but this was a price worth paying since it increased committee ownership and commitment.

Independence and commitment were also fostered through election of chairpersons. This is not to say that district coordinators did not play a vital role. In fact, the many functions performed by the coordinators often served as the "grease" which kept the committees moving. Having a person to carry through on committee details was recognized by many committees as an essential ingredient that was missing in previous attempts to collaborate. Even though their role was vital, coordinators did not want committees to become dependent on them. Electing a chairperson reduced this dependence. The fact that all of the committees have decided to continue to meet beyond the duration of this project is both an indication of their independence as well as a testimony to their own feelings of success.

This sense of accomplishment was an extremely important factor that kept alive the enthusiasm and motivation of the committee members. This more than any other factor explains the committees' desire to continue meeting.

In the one county where a chairman was not elected until the end of the project period, many of the committee members had experienced several recent failures at getting preschool programs to collaborate. This appeared to be a major factor in delaying their collabortive process. Committee members began with little confidence that this effort would work either. They had to develop a sense of trust in the district coordinator as well as in each other before they seemed willing to invest their time and energy. The fact that in the end even this committee elected a chairperson and decided to continue is indication that if implemented well, over time, the CARE Linkages model can stimulate the sense of confidence and trust needed in collaborative efforts.

Another observation of the project was that the committees that functioned best selected one or two projects in which the entire committee had a vested interest and where each committee member was involved in some way in carrying out the project. In the few committees where this was not the case, not as much was accomplished, attendance at meetings fluctuated considerably, and the group was much less cohesive.

As already mentioned, the district coordinators carried out many key functions in support of these committees. Prior to establishing any committee, they were familiarized with factors which are known to enhance or impede collaboration. Throughout the project, coordinators reinforced the positive factors and helped committees steer away from the pitfalls to collaboration. Coordinators provided a great deal of support to the committee chairperson and, particularly in the early stages, provided encouragement and leadership which kept the committees motivated and confident that they could address some serious needs. In terms of support, coordinators scheduled meetings, mailed correspondence, took minutes, and publicized committee activities in local and statewide news media. The value to committee success of having someone carry out these seemingly minor functions should not be overlooked.

Another lesser factor that contributed to the success of the Local CARE Committees was the fact that the Core CARE Committee existed. Many committee members were pleased and apparently more willing to participate because a state-level committee existed which they felt could address some of the policy and regulation problems which inhibit collaboration and linkages. In reality, there were not that many barriers identified by the local committees which were referred to the Core CARE Committee. Nor did the state-level committee actively seek to identify and deal with barriers which the local committees did not identify. Communication regarding barriers was increasing toward the end of the project. Perhaps with more time, this anticipated relationship between the state and local committees would have been more fruitful. However, even though Core Committee members wished that more local barriers had been identified for them to deal with, and local committee members expressed some disappointment over the lack of dramatic changes at the state level, members of both level committees still felt that having both state and local committees was an important ingredient to successful collaboration.

Even though the attention of this project was focused on the outcomes of the local committees, collaborative efforts in the Core CARE Committee were also desired. In contrast to the local committees, the Core Committee got off to a much slower start, met less regularly, and did not identify and carry out a specific committee project. These differences in committees appear to be closely associated with factors that enhance or inhibit collaboration. For instance, the Core CARE Committee began meeting months before the local committees were formed. They also began meeting prior to the literature review or survey of related programs. Project staff were newly hired and were still in the process of fleshing in the model and determining an appropriate research design. Thus, at the first several meetings, Core CARE Committee members were asked to be advisors to a project which was still not clearly defined to staff, to identify desirable collaborative efforts before project staff had a clear concept of collaboration, and to address issues raised by local committees which had not yet been formed. In other words, throughout the first several meetings of the Core Committee, the project staff and thus the committee members themselves, lacked a clear sense of their roles. In addition, nothing similar to the local needs assessment had been done at the state level. The initial expectation of staff was that the committee members themselves would identify and begin to address barriers to collaboration at the local level. Committee members and staff struggled to identify barriers, but due to lack of consensus and the overall desire to respond to barriers identified by the local committees, this effort finally petered out. This confusion over role and the fact that staff were leading committee members through activities which were not necessarily perceived by members to be desirable or productive, left members wondering whether, in fact, they had a meaningful role. This degree of initial ambiguity and dissatisfaction left committee members with little feeling of success. It undoubtedly contributed to the fluctuations in attendance, lack of cohesiveness and the fact that the committee members themselves did not select and carry out a collaborative project. Another extenuating factor which contributed to role confusion was change of project staff. Due to a resignation halfway through the project, a new state link-ages coordinator was hired.

Once this initial sense of confusion and concern set in, it was extremely difficult to overcome. In fact, it was not until the local

committees began to initiate their projects and communicate some barriers to the Core Committee that the state committee members gained a sense of purpose and satisfaction over being involved in this project. At the conclusion of the project, the Core CARE Committee members did feel that the project had succeeded and expressed pride in what the local committees had accomplished. the Core Committee was also pleased that it had responded to some degree to the barriêrs to collaboration that had been raised by the local committees. In addition, they felt they had played a significant role in identifying problems and making recommendations in regard to mental health services to preschoolers which appear, at this time, to be stimulating some positive changes.

In conclusion, it appears that the CARE Linkages Model, consisting of state and local-level committees, can quickly stimulate significant collaborative efforts to address long-time community problems in addressing health, education, and social service needs of preschool children. It is also apparent from this project that a variety of factors will impact on the success of collaborative efforts regardless of the geographic or population characteristics of the community.

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ADDENDUM A

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ADDENDUM B

PRESCHOOL PROGRAM LINKAGES SURVEY

Program _____ Program Code ___ ___

Respondent _____ Title Code ___ ___
(name and title)

County _____ County Code ___ ___

Region _____ Region Code ___ ___

Interviewer _____ Interviewer Code ___ ___

Date _____

Time started _____

Time ended _____

Section A Program Background

My first set of questions concern your program and the children you serve.

1. First, What ages are served by your program? (circle all that apply) [do not read categories]

   0 1 2 3 4 5 6 7 8 9 10

2. On an average day, what is your enrollment; that is, how many children do you serve?

   _____ children

3. How many children can your program serve; that is, what is your program's licensed capacity?

   _____ children

We are also interested in the children you serve and the conditions they may have

4. Which of the following conditions do you usually serve?

Yes	No	
1	2	Normally developing
1	2	Low income/poverty
1	2	Blind
1	2	Deaf
1	2	Physically Impaired (Orthopedic)
1	2	Health Impaired

		(including autistic)
1	2	Seriously Emotionally Disturbed
1	2	Visually Impaired
1	2	Hearing Impaired
1	2	Speech Impaired
1	2	Mentally Retarded and/or Developmentally Delayed
1	2	Specific Learning Disabilities
1	2	At Risk of Mental Retardation/Developmental Delay
1	2	Gifted

5. Which could you serve:

Yes	No	
1	2	Normally developing
1	2	Low income/poverty
1	2	Blind
1	2	Deaf
1	2	Physically Impaired (Orthopedic)
1	2	Health Impaired (including autistic)
1	2	Seriously Emotionally Disturbed
1	2	Visually Impaired
1	2	Hearing Impaired
1	2	Speech Impaired
1	2	Mentally Retarded and/or Developmentally Delayed
1	2	Specific Learning Disabilities
1	2	At Risk of Mental Retardation/Developmental Delay
1	2	Gifted

6. [For programs other that Head Start]

a. Do you have specific eligibility criteria for enrollment?

1 Yes 2 No 3 Don't know/not sure

b. {IF YES}: What are these criteria?

7. a. [Head Start only] Does your program apply only certain set of Head Start eligibiity criteria for enrollment? That is, are there any Head Start criteria that do not apply to your program?

   1. Yes, apply only certain set
   2. No, apply all Head Start criteria [go to #8]
   3. Don't know/not sure [go to #8]
   4. N/A

   b. [if yes to 7a] Could you briefly describe these criteria?

8 a. [Head Start only] Does your program have any additional criteria?

   1 Yes, additional criteria
   2 No, just Head Start criteria
   3 Don't know/not sure

   b. [if yes to 8a] Could you briefly describe these criteria?

9. How many of each of the following types of direct service staff does your program have?

   a._____ full time teachers
   b._____ part time teachers
   c._____ full time assistant teachers or aides
   d._____ part time assistant teachers or aides

10. How many of each of the following types of administrative and support staff does your program have?

   a._____ social workers
   b._____ program coordinator/assistant
   c._____ health coordintor/nurse
   d._____ cooks or food services staff
   e._____ janitorial staff

f._____ secretarial or office staff
g._____ transportation staff (van or bus drivers)
h._____ other (describe) _____

11. How many volunteers does your program have?

_____ volunteers

12. How many separate centers are operated within this program or is it a single center? {if it is a single center, write in 01}

___ ___ separate centers

13. Does your program serve children in their own homes or do the children come to you?

1 serve in homes
2 serve in center
3 both home and center based
4 other (describe)_____

14. How many days per week does your program serve children?

_____ days

15. What are your program's normal operating hours?

_____ time open _____ time closed

16. Does your program operate in the summer?

1 Yes 2 No {go to #19}

17. Is your summer program different from your regular school year program?

1 Yes 2 No {go to #19} 3 N/A

18. Could you briefly describe this difference?

19. Does your program offer respite care? By respite care, we mean occasionaly keeping childen over the weekend or for a few overnights during the week?

1 Yes
2 No
3 Other (explain)_____

20. Do you have a nutrition education program for your children or staff?

1 Yes, for staff
2 Yes, for children
3 Yes, for both
4 No
5 Other (describe)_____

21. [if yes to #19] Is this a USDA nutrition program or some other type of program?

1 USDA
2 Other (describe)_____

22. Is your overall program considered a public, private not for profit, church sponsored, or some other classification?

1 Public
2 Private not for Profit
3 Church-sponsored
4 Other (describe)_____

23. What is your funding source or sources? (Circle all that apply)

1 Head Start
2 Title XX (Child Development and Day Care)
3 Preschool Incentive Grant
4 Child Health and Development
5 MHMR
6 DD
7 Other public (describe)_____
8 Private (describe)_____

24. What regulations is your program required to follow? (Circle all that apply)

1 DHS Licensure (if yes, also circle 4 & 5)
2 MH/MR Licensure standards
3 AC MRDD accreditation standards
4 State and/or local fire codes
5 State and/or local health/environment codes
6 Department of Education standards
7 Head Start standards (performance or monitoring site visits)

8 Other (describe)_____

25. How many years has your program been in operation?

_____Year(s)

26. Have you experienced any recent cutbacks in financial support?

1 Yes 2 No

27. {IF YES} From which sources? (Circle all that apply)

1 Head Start
2 Title XX (Child Development - Day Care)
3 Preschool Incentive Grant
4 Child Health and Development
5 MHMR
6 DD
7 Other public (describe) _____
8 Other private (describe)_____
9 N/A

28. Do you expect any financial cutbacks within the next year?

1 Yes 2 No

29. {IF YES} From which sources (circle all that apply).

1 Head Start
2 Title XX (Child Development and Day Care)
3 Preschool Incentive Grant
4 Child Health and Development
5 MHMR
6 DD
7 Other public (describe)_____
8 Private (describe)_____
9 N/A

PRESCHOOL PROGRAM SURVEY

Section B Possible Linkage Services and Activities

I would now like to ask you several questions about some services and activities that are believed to be important for preschool children. Most of my questions will be aimed at learning more about the activities and services your program offers. We are particularly interested in those activities and services in which you collaborate or work with other service providers. These providers do not have to be preschool providers.

We're also interested in learning about these activities in which you would be willing to collaborate or work with others. I do want to stress, however, that we are interested only in you openness to the idea of collaboration in these activities--we are not asking for any informal or formal commitment. (Read each activity and appropriate questions.) Again, I would like to repeat our definition--by collaboration, we mean a voluntary arrangement set up between two or more organizations that involves coordination of services or actual sharing of resources.

		II. Do you collaborate or work with other service providers in conducting this service? Yes (Go to next question) No (Go to III)	III. Would you be willing to collaborate or work with others on (activity)? Yes (Go to next activity) No	IV. Would you like to provide this activity/service? Yes (Go to V) No (Go to next activity)	V. Would you be willing to collaborate or work with others on (activity)? Yes (Go to next activity) No
I. Does your program currently:	YES		NO	NO	
Participate in planning for each child's entry into the public school system?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	Yes No	Yes No
Include home visits?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	Yes No	Yes No
Provide or secure assessments, evaluations, and screening for educational, physical health, or mental health purposes?	YES	Yes No with whom?_____ on what basis_____ (regular or other)	Yes No	Yes No	Yes No
Provide inservice training or educational workshops for staff and parents?	YES	Yes No with whom?_____ on what basis_____ (regular or other)	Yes No	Yes No	Yes No

	II. Do you collaborate	III. Would you be or work with other service providers in conducting this service? Yes (Go to next question) No (Go to III)	IV. Would you like to willing to collaborate or work with others on (activity)? Yes (Go to next activity) No	V. Would you be willing to provide this activity/service? Yes (Go to V) No (Go to next activity)	collaborate or work with others on (activity)? Yes (Go to next activity) No
YES			NO		

I. Does your program currently:

Organize or encourage staff or parents to influence policymakers on behalf of children?	YES	Yes	No	Yes	No	NO	Yes	No	Yes	No
		with whom?_____ on what basis?_____ (regular or other)								
Attempt to promote public awareness of children's needs?	YES	Yes	No	Yes	No	NO	Yes	No	Yes	No
		with whom?_____ on what basis_____ (regular or other)								
Attempt to pro awareness of you program's services?	YES	Yes	No	Yes	No	NO	Yes	No	Yes	No
		with whom?_____ on what basis_____ (regular or other)								
Attempt to identify potential sources or contributions such as volunteers, money, materials, or fac ties?	YES	Yes	No	Yes	No	NO	Yes	No	Yes	No
		with whom?_____ on what basis?_____ (regular or other)								
Provide or secure social services for your children and their families?	YES	Yes	No	Yes	No	NO	Yes	No	Yes	No
		with whom?_____ on what basis?_____ (regular or other)								

I. Does your program currently:	YES	II. Do you collaborate or work with other service providers in conducting this service? Yes (Go to next question) No (Go to III)	III. Would you be willing to collaborate or work with others on (activity)? Yes (Go to next activity) No	NO	IV. Would you like to provide this activity/service? Yes (Go to V) No (Go to next activity)	V. Would you be willing to collaborate or work with others on (activity)? Yes No (Go to next activity)
Provide or secure nutrition education for your children and their families?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	NO	Yes No	Yes No
Provide or secure a nutrition education training program for your staff?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	NO	Yes No	Yes No
Provide or secure mental health services for your children and their families; for example counseling.	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	NO	Yes No	Yes No
Provide or secure medical or health services for your children?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	NO	Yes No	Yes No
Provide or secure dental services for your children?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	NO	Yes No	Yes No

I. Does your program currently:		II. Do you collaborate or work with other service providers in conducting this service? Yes (Go to next question) No (Go to III)	III. Would you be willing to collaborate or work with others on (activity)? Yes No (Go to next activity)		IV. Would you like to provide this activity/service? Yes (Go to V) No (Go to next activity)		V. Would you be willing to collaborate or work with others on (activity)? Yes No (Go to next activity)	
Provide or secure legal services for families?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes	No	NO	Yes	No	Yes No
Provide information and referral services for children your program is not able to serve?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes	No	NO	Yes	No	Yes No
Have parent groups?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes	No	NO	Yes	No	Yes No
Provide assistance to parents regarding needed services such as Alcoholics Anonymous?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes	No	NO	Yes	No	Yes No
Provide children and their families with any materials and resources for home use?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes	No	NO	Yes	No	Yes No

I. Does your program currently:		II. Do you collaborate or work with other service providers in conducting this service? Yes (Go to next question) No (Go to III)	III. Would you be willing to collaborate or work with others on (activity)? Yes (Go to next activity) No	IV. Would you like to provide this activity/service? Yes (Go to V) No (Go to next activity)	V. Would you be willing to collaborate or work with others on (activity)? Yes (Go to next activity) No
Serve as a field or practicum site for students?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	NO Yes No	Yes No
Provide physical education or recreation time for your children?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	NO Yes No	Yes No
Provide special art activities?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	NO Yes No	Yes No
Provide special music activities?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	NO Yes No	Yes No
Provide occupational or physical therapy?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	NO Yes No	Yes No

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I. Does your program currently:		II. Do you collaborate or work with other service providers in conducting this service? Yes (Go to next question) No (Go to III)	III. Would you be willing to collaborate or work with others on (activity)? Yes (Go to next activity) No	IV. Would you like to provide this activity/service? Yes (Go to V) No (Go to next activity)	V. Would you be willing to collaborate or work with others on (activity)? Yes (Go to next activity) No
Provide speech therapy?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	NO Yes No	Yes No
Formulate individual goals and a service delivery plan for each child? (i.e., IEP, etc.)	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	NO Yes NO	Yes No
Provide or secure transportation for children to and from your program's center?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	NO Yes No	Yes No
Provide or contract for transportation for children to special services within or outside your community.?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	NO Yes No	Yes No
Use any facilities other than your center for special events or services on a regular basis?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	NO Yes NO	Yes No

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I. Does your program currently:	YES	II. Do you collaborate or work with other service providers in conducting this service? Yes (Go to next question) No (Go to III)	III. Would you be willing to collaborate or work with others on (activity)? Yes No (Go to next activity)	NO	IV. Would you like to provide this activity/service? Yes (Go to V) No (Go to next activity)	V. Would you be willing to collaborate or work with others on (activity)? Yes No (Go to next activity)
Pay for maintenance or janitorial services?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	NO	Yes NO	Yes No
Pay for accounting or other administrative services?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	NO	Yes No	Yes No
Purchase supplies or food in large quantities and/or at wholesale prices?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	NO	Yes No	Yes No
Purchase insurance for use of certain facilities or for transportation?	YES	Yes No with whom?_____ on what basis?_____ (regular or other)	Yes No	NO	Yes NO	Yes No
Other (describe).						
Other (describe)						

Section C Other Collaborative Activities

In addition to the services and activities we have just read through, there are several other types of collaborative and networking activities that are possible for preschool programs. I am going to read several activities and would like you to please tell me the ones your program has participated in.

Does your program currently participate in:	I. Yes (go to next activity)	I. No (go to II)	II. Would you be interested in participating in this type of activity in the future? Yes	II. No (go to next activity)
1) Statewide, county, or local interagency conferences or workshops?	Yes 1	No 2	Yes 1	No 2
2) Statewide, county, or local interagency committees or councils?	Yes 1	No 2	Yes 1	No 2
3) Professional organizations such as the Tennessee Association on Young Children (TAYC), Child Development Association of Tennessee, National Association of Social Workers and others	Yes 1	No 2	Yes 1	No 2
4) Department of Education Child Find Activities or other child identification activities?	Yes 1	No 2	Yes 1	No 2
5) Information exchange with other service providers?	Yes 1	No 2	Yes 1	No 2
6) Sharing direct service staff with other pre-school programs?	Yes 1	No 2	Yes 1	No 2
7) Joint discussions with other service providers on specific children's progress and problems?	Yes 1	No 2	Yes 1	No 2
8) Joint scheduling with other programs for health and social services?	Yes	No	Yes	No

{Before proceeding to Section D, say}:

I would like to have your permission to share the information you have just provided about services and activity and any information about your collaboration experiences with the district coordinator from our agency. We feel this information could be extremely helpful to the district coordinator in learning more about her district and the needs of its preschool programs. This information will be shared only if your county is randomly selected to participate in collaborative workshops. Also, only this information would be shared—information from all other sections of this interview will remain confidential and anonymous District coordinators will be provided with the information from other sections of this interveiw only in group and summary form.

May I have your permission to share the activity information with your _____ (coordinator name)?

1 Yes 2 No

Section D Knowledge and awareness of other preschool services

My next questions concern the other preschool programs and services available in your area.

1. There are several programs for preschool children in your service delivery area. Could you name the ones you know or have heard of? (if no programs are listed, go to #4)

: these programs, how many would you say that you know well?

1 all
2 most
3 some
4 few
5 none
6 N/A

3. How often would you say you or someone in your staff is in contact with one or more other preschool programs in your area? Would you say: (Circle only one).

1 at least once a day
2 at least three times a week
3 at least once a week
4 at least twice a month
5 at least once a month
6 at least once a year
7 never
8 other (describe)_____
9 N/A

4. How often would you say your program is in contact with your county health department? Would you say: (Circle only one)

1 at least once a day
2 at least three times a week
3 at least once a week
4 at least twice a month
5 at least once a month
6 at least once a year
7 never
8 other (describe)_____

5. How often would you say your program is in contact with any type of mental health service such as community mental health centers, private psychologists, or other types of similar services? Would you say: (Circle only one)

1 at least once a day
2 at least three times a week
3 at least once a week
4 at least twice a month
5 at least once a month
6 at least once a year
7 never
8 other (describe) _____

6. How often would you say your program is in contact with human services such as DHS? Would you say: (Circle only one)

1 at least once a day
2 at least three times a week
3 at least once a week
4 at least twice a month
5 at least once a month
6 at least once a year
7 never
8 other (describe) _____

7. How often would you say your program is in contact with private health care providers such as doctors, nurses, dentists, and others?

1 at least once a day
2 at least three times a week
3 at least once a week
4 at least twice a month
5 at least once a month
6 at least once a year
7 never
8 other (describe) _____

8. [if not a public school program]: How often would you say your program is in contact with the local school system?

1 at least once a day
2 at least three times a week
3 at least once a week
4 at lest twice a month
5 at least once a month
6 at least once a year
7 never
8 other (describe)_____

9. Of the service providers in your region, which ones do you feel work most cooperatively for the good of preschool children? [if lists only one or two]: Are there any others that come to mind?

Section E Attitudes toward collaboration

I would now like to read you several statements about program and agency collaboration. For each statement, I would like to know the degree to which you agree or disagree with the statement. As I am going to read you a number of statements, it may be helpful to jot down the 5 categories of possible answers. these categories [READ slowly] are strongly agree, agree, neither agree nor disagree, and strongly disagree. [Repeat if necessary.]

The first statement is

My program could benefit from collaboration.

Would you say you strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree with this statement?

Mark answer near #1 below]

How about—[read #2 and so on in the same manner as above]

1.	My program could benefit from collaboration.	SA	A	N	D	SD	DK
2.	Programs in this region are too concerned about protecting their own turf to want to collaborate.	SA	A	N	D	SD	DK
3.	Collaboration can lead to more complete services for preschool children presently served.	SA	A	N	D	SD	DK
4.	Working with other programs on any long-term basis is an impossible task.	SA	A	N	D	SD	DK
5.	Most programs gain from collaboration.	SA	A	N	D	SD	DK
6.	Collaboration takes too much of a program's time.	SA	A	N	D	SD	DK
7.	Collaboration decreases the amount of red tape for a program.	SA	A	N	D	SD	DK
8.	Collaboration would increase the conflicts among programs in this area.	SA	A	N	D	SD	DK
9.	Collaboration helps a program to have positive relations with other programs.	SA	A	N	D	SD	DK
10.	Good staff members are more likely to stay with a program that collaborates with other service providers.	SA	A	N	D	SD	DK

11.	Collaboration increases the time spent on paperwork.	SA	A	N	D	SD	DK
12.	Collaboration would create better communication among preschool providers in this area.	SA	A	N	D	SD	DK
13.	Collaboration costs too much money.	SA	A	N	D	SD	DK
14.	If programs collaborated, they would be less likely to individually offer the same services.	SA	A	N	D	SD	DK
15.	Competition for resources would increase if preschool programs collaborated.	SA	A	N	D	SD	DK
16.	More children could be served if preschool programs and providers collaborated.	SA	A	N	D	SD	DK
17.	By collaborating, my program would have to be more accountable to money spent on program operations.	SA	A	N	D	SD	DK

Section F Perceptions of collaboration consequences

There are a number of things that could happen as a result of cooperatively working with other service providers. I would like to read you several things that could happen. For each, please tell me if you believe it would improve, get worse, or remain the same if preschool providers in your area worked cooperatively.

The first is the quality of planning for preschool services.

Do you believe the quality of planning could improve, get worse, or remain the same?

{Mark answer below next to # 1 and continue to read items in the same manner}

{If the respondent says improve or get worse}: How much do you think it could improve (worsen): a great deal or just a little?

	Improve		Remain the	Get Worse		
	a great deal	a little	same	a little	a great deal	don't know
1. Quality of planning for preschool services.	1	2	3	4	5	9
2. Use of existing services and resources.	1	2	3	4	5	9
3. Communication among preschool programs and service providers.	1	2	3	4	5	9
4. Relationships among preschool programs	1	2	3	4	5	9
5. Availability of a variety of services to children.	1	2	3	4	5	9
6. Use of your program staff's time.	1	2	3	4	5	9
7. The ability of service providers to identify children with health, education, or social service needs.	1	2	3	4	5	9
8. Advocacy for children.	1	2	3	4	5	9
9. Morale among your staff.	1	2	3	4	5	9

		Improve		Remain the	Get Worse		
		a great deal	a little	same	a little	a great deal	don't know
10.	Quality of inservice staff training.	1	2	3	4	5	9
11.	The appropriateness of future placements for your program's children.	1	2	3	4	5	9
12.	Sharing information regarding new practices of serving preschool children.	1	2	3	4	5	9
13.	Your program's awareness of other available services and programs.	1	2	3	4	5	9
14.	Your program's ability to serve more children than it does now.	1	2	3	4	5	9
15.	Your program's ability to provide more services or activities to the children you presently serve.	1	2	3	4	5	9
16.	Your program's ability to track and follow up on the children served.	1	2	3	4	5	9
17.	Morale of preschool programs in your area.	1	2	3	4	5	9

Section G Barriers

In this section, I would like to go through some possible problems that some people say block collaboration. For each, I would like to ask you how big a problem you believe it is for your region.

The first barrier is limited program budgets.

How much of a problem do you believe this is for your area--A large problem, a moderate problem, a small problem, or not at all a problem?

[mark answer next to #1 below]

How about [read #2 and so on]

	large problem	moderate problem	small problem	not a problem	don't know
1. Limited budgets.	1	2	3	4	9
2. The case of one or two programs typically receiving more attention from civic groups than other preschool programs.	1	2	3	4	9
3. Personality clashes among preschool program directors.	1	2	3	4	9
4. Poor communication among preschool programs.	1	2	3	4	9
5. Poor communication between programs and other service providers.	1	2	3	4	9
6. Unwillingness of programs to share resources.	1	2	3	4	9
7. Too much government control.	1	2	3	4	9
8. Lack of trust between programs.	1	2	3	4	9
9. Political dominance of one or two programs.	1	2	3	4	9
10. Lack of time to work together.	1	2	3	4	9
11. Lack of desire of programs to work together.	1	2	3	4	9

Section H Program Director characteristics

I would now like to ask you a few brief questions about your background.

1. How long have you been with this program?

_____months and/or _____years

2a. How long have you served as the program's director?

_____months and/or _____years

b. Do you work fulltime or part-time in this position?

1 fulltime
2 part-time
3 other (describe)_____

3. [If #2 is less than #1 - What other position or positions have you held in this program?

4. Have you been employed by any other preschool programs?

1 Yes 2 No

5. [If yes]: What type of program(s)?

6. [If yes to #4]: What positions did you hold? For how long?

7. Have you had any other experience in human service delivery programs or agencies?

1 Yes 2 No

8. [If yes]: Could you briefly describe this experience (find out description, position, number of years)

9. What was your last completed year of school? [DO NOT READ CATEGORIES]

1 GED
2 high school
3 some college
4 college degree
5 some graduate work
6 master's degree
7 post-master's
8 Ph.D.
9 Other _____

10. [If college degree or greater]: What was your major area of study?

11. [If Head Start]: Are you working on or have you received a Child Development Associate (CDA)?

1 Yes - have or currently working on
2 No - do not have
3 N/A

12. And finally, for statistical purposes, it would be helpful if we could know the year in which you were born: _____.

13 Sex [DO NOT ASK]:

1 Female 2 Male

Thank you so much for all your help. Do you have any questions you would like to ask me?

Once we have completed our interviews with all selected program directors, _____ (district coordintor) will be contacting you to let you know whether your county has been randomly picked to have a committee formed.

Once again, thank you for your time and cooperation.

ADDENDUM C

The survey questionnaire used to gather information on other collaborative projects follows:

INTERVIEW WITH COLLABORATION PROJECTS

Project title_____ Date_____

Contact person_____ Time started_____

Phone #_____ Time Ended_____

Interviewer_____

Introduction

[READ]: Hello, may I please speak with _____(contact person)?

[If he or she is no longer there, ask to speak with someone else who may have been or is affiliated with_____(project name). If there is no one who knows about the project, ask for the telephone number and current address of the original contact person.]

[ONCE YOU HAVE REACHED THE CURRENT PERSON:]

Hello, (Ms./Mr.) (contact person) ? My name is _____. I'm calling from the Tennessee Children's Services Commission. Our agency is presently working on a project to improve the coordination of services for children in preschool programs. I believe you were involved in a similar project,_____(project name).

We learned of your project from a report on the Child Health Conference proceedings held at the University of Colorado in 1980 and felt it would be helpful to get additional information about your efforts and experiences. You were suggested as someone who would be able to provide this type of information.

Is this a good time to ask you several questions about the project?
[IF NO]: Would it be possible to schedule a time to talk within the next few days?
[RECORD DAY AND TIME]

A. PROJECT BACKGROUND [READ]: I first would like to learn a little bit more about the project's background.

1.) When was the project initiated? That is, in what year was it begun?

2.) Why was the project begun?

3.) What was the original funding source for the project?

4.) Is the project still in operation?

[If YES—GO ON TO SECTION B]

5.) When did the program end?

6.) Why was it terminated? (for example, funding problems; no longer needed by agencies; problems with acceptance; etc.)

B. Project Description

[READ]: Although I know a little about your project from the Child Health Conference abstract, I wonder if you could provide me with a bit more description. In particular, I am interested in learning about several specific aspects of your project.

1.) What were the project's major goals and objectives?

2.) What types of agencies were involved?
(For example, preschool programs, handicapped programs, etc.)

3.) What populations were served by these agencies?
(For example, handicapped youth between the ages of 0 and 5; etc.)

4.) In what types of geographic/demographic areas did the project operate?

5.) What were the reasons why these areas were selected?
(For example, we are planning to implement the project in four different geographic areas and believe there will be differences concerning the types of collaboration that are possible in each of these areas).

6.) On what level did the project operate? That is, was it a statewide, regional, county, or community level project?

7.) [IF THE PROJECT IS STILL IN OPERATION] Is the project operating in the same format and what changes, if any, have had to be made to maintain the project? (For example, implement the strategies in fewer areas)

C. Collaboration Description [READ]: My next questions focus on the type of collaboration stategies that were used in your project.

1.) Did you use a particular type of collaboration model; that is, a particular method of initiating collaboration? (For example, committee, lead agency model, third party consultant, etc.) [We are using an interagency committee model or what is sometimes called an interagency council model--it involves forming a committee of agency representatives and having them decide on appropriate collaboration strategies]

2.) Why did you choose this model?

3.) What aspects of the program were involved in the collaboration efforts? That is, did the agencies coordinate or collaborate on:

a - services (if so, what types?)

b - skills (if so, what types?)

c - staff (if so, what types?)

d - resources (if so, what types?)

e - facilities (if so, what types?)

f - any other specific aspects (briefly describe)

4.) What helped you to decide which of these aspects we just discussed should be included in the collaboration efforts?

5.) How were the agreements to collaborate reached?

6.) Were the agreements formal and written, informal, or a combination of formal and informal agreements?

7.) What factors determined the type of agreement that was used?

8.) What binds (or did bind) the agreements among agencies?

9.) Was it your feeling that all parties involved were benefiting in some way by collaborating?

10.) How many agencies or parties were involved in each of the different collaborative agreements?

11.) [IF THE PROJECT HAS BEEN TERMINATED]: Do the agreements continue to exi[illegible]ven though the project is no longer in operation?

D. Assessment [READ]: Since our project has been funded as a research and demonstration project, we are very interested in developing assessment instruments to measure various aspects of the collaboration process. So we are anxious to learn the assessment efforts of the projects like _____ _____(project name).

1.) How did you know what collaborative efforts were needed for your project — that is, did you conduct any type of needs assessment?

2.) What were the needs that you identified?

3.) How did you know what types of collaborative efforts would be acceptable? That is, did you attempt to assess agency attitudes toward collaboration or attitudes toward each other?

4.) What were the most acceptable types of efforts or strategies? (that is, the types of collaboration that agencies found most beneficial?)

5.) What were the least acceptable?

6.) Were there any particular reasons for some collaborative efforts being more successful than others?

7.) Did you attempt to identify barriers to forming collaborative agreements? By barriers, I am referring to physical as well as psychological and political aspects of the environment that may prevent agencies or parties from effectively linking together.

8.) What were the major barriers?

9.) Overall, how successful were the project's efforts?

10.) How did you measure success - that is, did you evaluate the effectiveness of your project?

11.) [IF AN EVALUATION WAS USED]: What type of evaluative procedures did you use?

12.) Over time, were there changes in the original agreements of collaborative relationships between and among agencies? (For example, did informal agreements become formal?)

[IF ANY INSTRUMENTS WERE USED, ASK IF THEY ARE AVAILABLE. IF YES, REQUEST THAT THEY BE SENT AND DOCUMENT WHICH ARE TO BE RECEIVED].

E. Additional Considerations [READ]: My last few questions are an attempt to obtain additional information that may aid us in anticipating problems in implementing and conducting our project.

1.) What problems, if any, did you confront in implementing your project? (For example, budget and policy restrictions; negative attitudes or misperceptions concerning collaboration; lack of feasibility; lack of "real need"; regional issues peculiar to that area or to the types of agencies involved; [ask for explanation or elaboration if necessary]).

2.) Were there any collaboration strategies that were tried but were dropped or replaced?

3.) [IF YES TO #2]: What were they?

4.) Is there any written information available about the findings of _____ _____(project name) that I could receive? [IF YES, REQUEST AND DOCUMENT].

5.) Is there anyone else I should contact for additional information on this project or other projects?

6.) [IF YES TO #5]: Would you know how to contact these individuals?

7.) Could you suggest any other sources I should look at? (That is, any books, articles, project reports).

F. Closing Remarks I centainly appreciate the time and information you have shared with me regarding the _____(project name). Are there any questions you would like to ask me about our agency's project? [NOTE IF WRITTEN INFORMATION IS REQUESTED].

Once again, thank you for your assistance.

ADDENDUM D

Meeting No. _____ County _____

Meeting Date _____

COMMITTEE MEETING CLIMATE SURVEY

1. Willingness to accept task responsibility:

   Of _____ persons assigned committee tasks for this meeting, _____ persons completed tasks.

   Comments: _____

   _____

2. Source of meeting leadership:

   Coordinator _____ Elected Chairperson _____

   Appointed Chairperson _____ Substitute Chairperson _____

   Comments: _____

   _____

3. Style of Leadership:

Committee ignores Coordinator		Committee Includes Coordinator as just another member		Committee partially dependent on Coordinator to lead		Committee totally dependent on Coordinator to lead
1	2	3	4	5	6	7

   Comments: _____

   _____

4. Number of persons who participated:

Few		Some		Many		All
1	2	3	4	5	6	7

   Comments: _____

   _____

5. Number of members who generated ideas:

Few		Some		Many		All
1	2	3	4	5	6	7

   Comments: _____

   _____

Meeting No. _____ County _____

Meeting Date _____

6. Number of members willing to work together:

Few		Some		Many		All
1	2	3	4	5	6	7

Comments: _____

_____

7. Attitude toward working together:

Very Negative		Slightly Negative		Slightly Positive		Very Positive
1	2	3	4	5	6	7

Comments: _____

_____

8. Ease in agreeing on Committee Focus:

Never Agree		Sometimes Agree				Always Agree	
1	2	3	4	5	6	7	N/A

Comments: _____

_____

9. Degree of reality-based planning by the Committee:

Totally Unrealistic		Moderately Realistic				Totally Realistic	
1	2	3	4	5	6	7	N/A

Comments: _____

_____

10. Additional Comments on Meeting Climate:

_____

_____

_____

_____

_____ (use back if needed)